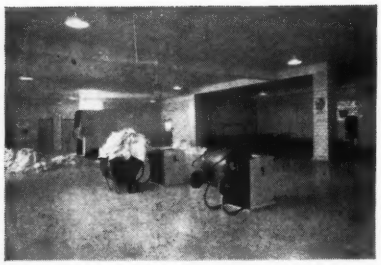
October, 1956

Canadian Hospital

- *St. Boniface Hospital.... enlarged and modernized*
- *Emergency Hospital Services*
- *The Nursing Team Carries On*
- *Hospital Administrators in Canada*
- *Medical Laboratory Technologists Meet*
- *Public Relations Through Motion Pictures*

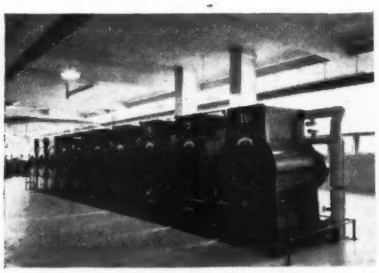
Canadian Hospital Association



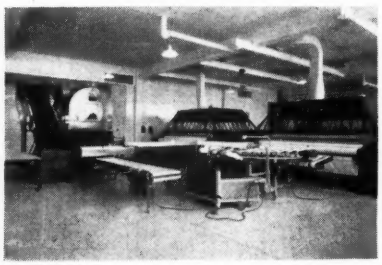
Work is sorted and classified in the soiled-linen room. It is then weighed and placed in easy-to-handle carts which are emptied into chutes leading to laundry.

Hoppers feed work from chutes directly into Cascade Unloading Washers. These large-capacity machines with Full-Automatic Controls are the ultimate in labor-saving equipment.

At the touch of a button hundreds of pounds of work are unloaded from washers into extractor containers. Overhead trolley and hoists convey containers to and from 60" Notrux Extractors.



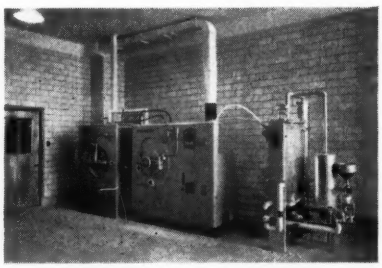
After extraction, work to be dried is conveyed to this battery of Zone-Air Tumblers. A total load capacity of 1100 lbs. indicates the tumblers' value in this high-production operation.



Completely mechanized flatwork finishing reduces operating personnel. Rotaire Conditioning Tumbler, Conveyors, Sager Spreader, Super-Sylon Ironers and Trumatic Folder speed-up work flow.

High-speed finishing of hospital garments and shirts rounds out variety of work laundry handles. Units include Super-Zarmo and Super-Zarmoette Presses and Tiltor Shirt Folder.

Three built-in Blanket and Curtain Dryers indicate the extent of planning and complete range of equipment supplied by the Canadian Laundry Machinery Company in this model installation.



An important part of the all-inclusive service performed by this modern department is the Model 30 Deluxe American-Martin Dry Cleaning Unit. Cleans up to 120 lbs. of work per hour.

Dry cleaning finishing is done with the latest model air-driven AceCo Presses. These presses assure fast, quality finishing with smooth, easy operation and maximum safety.

"Dream" Laundry for Canadian mental hospital

Modern premises, ample floor space and the world's finest laundry and dry cleaning equipment – make the laundry of St. Michel-Archange Hospital, Quebec, an ideal example of a fully equipped, efficient service department. The Canadian Laundry Machinery Company's planning help and complete line of equipment played an important role in creating this "dream" laundry. For complete information on how to streamline your laundry operation, write today.

Canadian

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WESTERN REPRESENTATIVES—Stanley Brock Limited, Winnipeg, Calgary, Edmonton, Vancouver

Contents

Vol. 33 OCTOBER, 1956 No. 10

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*Based on 4-ounce portions.

HEINZ TOMATO JUICE

TP-156 H&I

Notes About People

Robert G. Goodman,

Executive Secretary,
Associated Hospitals of Manitoba

(This is the fourth in a series introducing secretaries of provincial hospital associations.)

For the past four years, Robert Goodman, C.A., has been executive secretary of the Associated Hospitals of Manitoba, and its consulting accountant. Born and educated in Winnipeg, Mr. Goodman served overseas with the R.C.A.F. in World War II. He was discharged with the rank of Pilot Officer in 1945 and then resumed his studies in accounting. In 1950 he achieved his C.A. and joined a Winnipeg firm of chartered accountants. He was appointed to his present position in December, 1952.

Robert G. Goodman

In 1954, the Associated Hospitals of Manitoba, with financial assistance from the W. K. Kellogg Foundation, launched a program in accounting known as "Report Accounting". The program was designed to assist small hospitals in the province in accounting and reporting procedures, through a centralized accounting office (see *The Canadian Hospital*, March, 1955). In addition to his general secretarial duties with the association, the overall supervision of the centralized staff, necessary to operate the report accounting system, has been assigned to Mr. Goodman. It is, however, a job for which, with his background in accounting, he is well suited.

During the last week of this month, the 1956 Manitoba Hospital and Nursing Conference will be held in Winnipeg. The conference is a joint meeting in which ten separate organizations participate. Part of Mr. Goodman's yearly efforts are directed toward keeping a finger on all the vital organizational matters which are necessary to produce a smooth-running convention. With so many groups meeting at one time, the attention to innumerable details such as obtaining speakers, preparing an interesting and educational program, arranging for exhibits, selecting meeting rooms, et cetera, makes it no small task but it is one which Mr. Goodman carries out with efficiency and enthusiasm.

As a representative of the Associated Hospitals of Manitoba, Mr. Goodman serves on the board of trustees of the Upper Midwest Hospital Conference, which is a regional organization of the American Hospital Association taking in five northern midwest states and Manitoba. He is also a member of the Canadian Hospital Association's Committee on Accounting and Statistics.

• • • •

Administrator at Queensway General Hospital

Harry F. Garwood has been appointed administrator to Queensway General Hospital, Toronto, Ont. Prior to this, he has served as administrator at the Children's Hospital, Vancouver, B.C., North Vancouver General Hospital, Greater Niagara General Hospital, Niagara Falls, Ont., and Northwestern General Hospital, Toronto. Mr. Garwood is a graduate of the course in hospital organization and management sponsored by the Canadian Hospital Association.

• • • •

Visit of Physiotherapist from the U.K.

Gladys M. Storey, physiotherapist at St. Thomas' Hospital, London, England, has recently visited the U.S. to give a paper at the International Congress of Physical Therapy in New York. During her brief visit to Toronto, she toured the Toronto General Hospital and the Hospital for Sick Children, as well as Lyndhurst Lodge, and was impressed with rehabilitation work in Canada. Miss Storey stated that physiotherapy, in connection with chest surgery, is used much more extensively in Britain than on this continent. She is becoming internationally known through her book *Thoracic Surgery for Physiotherapists*, on sale in all Commonwealth countries, and soon to be published in the U.S.A.

• • • •

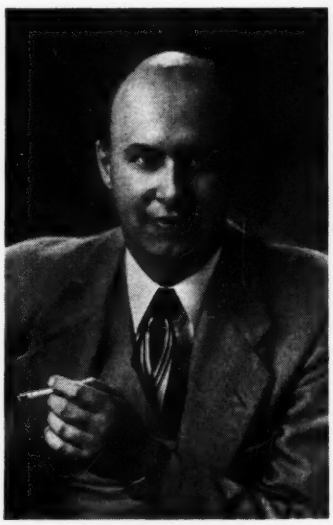
New Administrator for Peel Memorial Hospital

Howard K. Krafft, formerly assistant administrator at Sarnia General Hospital, Sarnia, Ont., has now assumed duties as administrator of Peel Memorial Hospital, Brampton, Ont. In 1953, Mr. Krafft received the certificate awarded those successfully completing the course in hospital organization and management given by the Canadian Hospital Association. Since 1947, he has been associated with hospital reorganization.

• • • •

Moves to Winnipeg Post

Robert M. Clements, C.A., formerly assistant director, (Accounting) Division of Hospital Administration and Standards, Department of Public Health, Saskatchewan, is now secretary of the Hospital Rate Board, Department of Health and Public Welfare, Manitoba, and has taken up residence in Winnipeg.

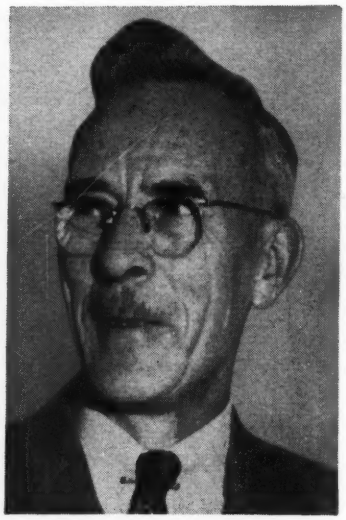


R. M. Clements

• • • •

Changes at St. Michael's Hospital

Four changes have been reported at St. Michael's Hospital, Toronto, Ont. Sister Maura, former superintendent, has become Reverend Mother Gen-



Edward Victor Walshaw

IT IS with a sense of sorrow that we record here the sudden death of Edward Walshaw, executive secretary of the Saskatchewan Hospital Association and a member of our board of directors. Mr. Walshaw had been working on reports for the convention of the Saskatchewan Hospital Association when he collapsed on September 21st at his home in Saskatoon. He was in his sixtieth year. He is survived by his wife, a son, Charles, and a daughter, Victoria.

Mr. Walshaw was the first full-time executive secretary of the Saskatchewan Hospital Association, having accepted that post in 1953 after 28 years of service with Saskatoon City Hospital. His death comes as a tremendous loss to all hospitals in Saskatchewan. He was elected to the board of directors of the Canadian Hospital Association at its biennial meeting in 1955.

The officers and directors of this association and those of member associations and conferences wish to join his many friends in expressing to Mrs. Walshaw and her family their deep sympathy.

(*Continued from page 12*)

eral of St. Joseph's Order. Sister M. Janet is the new superintendent. The latter holds a Diploma in Hospital Administration from the University of Toronto, spent her period of residency at St. Joseph's Hospital in Toronto, and was business manager at St. Michael's Hospital until her new appointment. Sister M. Raphael, a 1956 graduate in the Canadian Hospital Association's course in hospital organization and management, and formerly secretary treasurer of the hospital, is the new treasurer general of St. Joseph's Order. Sister M. Eugenie from St. Joseph's Hospital is the new secretary treasurer at St. Michael's Hospital. She also is a 1956 graduate of the C.H.A. course in hospital organization and management.

• • • •

Mrs. W. P. Fillmore

On August 5, the Manitoba Women's Hospital Auxiliaries Association lost a devoted fellow-worker and friend, with the death of Mrs. W. P. Fillmore, a past president of the association.

• • • •

Canton to Moncton

A husband and wife doctor team have arrived in Moncton, N.B., to serve a one-year internship in the Moncton Hospital. Graduates in medicine from the Sun Yat Sen University, Canton, and natives of Canton, Dr. C. Y. Kwan and his wife (who practises under her maiden name) Dr. Y. C. Yeung have a six-months-old son, Alexis. The Drs. Kwan would like to set up a practice in the Chinese quarter of a Canadian city after completing their internship.

• • • •

To Direct Research Project

Dr. Milton I. Roemer, director of medical and hospital services for the Saskatchewan public health department since 1953, has resigned to accept a position as director of a large-scale research project on co-ordination between hospitals and other community health and welfare agencies in 12 cities in the United States. Earlier, following studies at Cornell, New York, and Michigan universities, Dr. Roemer was on the faculty of Yale university, and in 1951 became chief of the World Health Organization's social and occupational health section.

• • • •

Director of Nurses, Sydenham

Bernice Healy, R.N., has been appointed director of nurses at the new Sydenham District Hospital, Wallaceburg, Ont. Miss Healy will organize a special training program for nurses aides and assistants, designed to supply adequate help for nurses in the new hospital, which will be in full use within a few weeks.

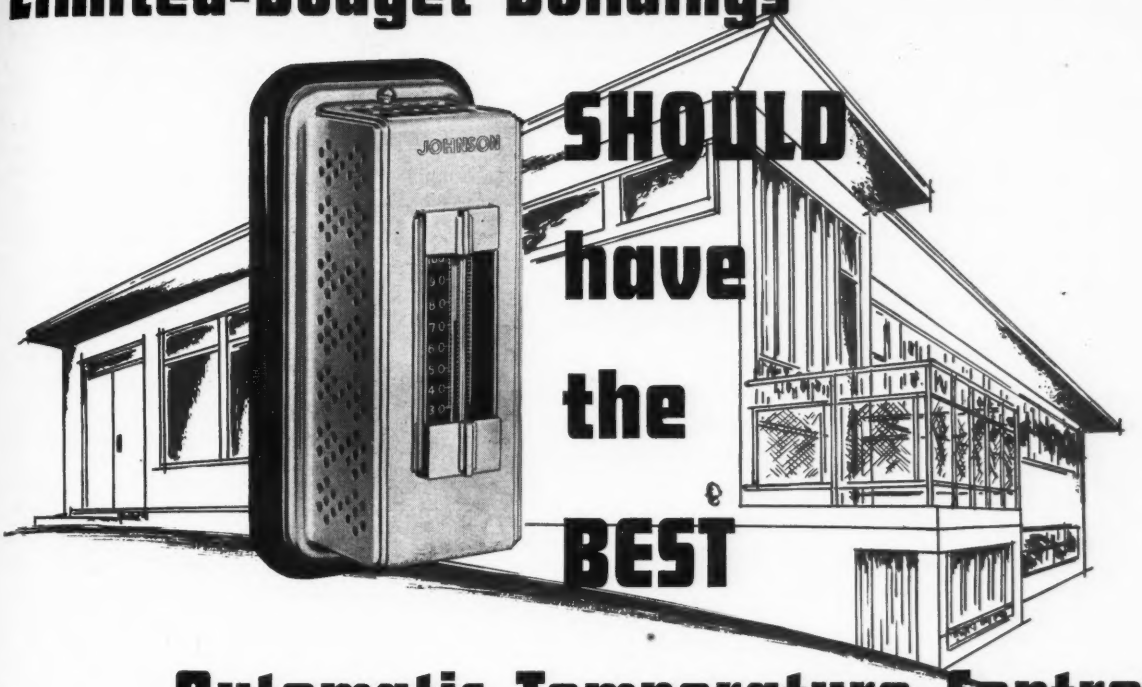
• • • •

New Superintendent of Nurses

Beatrice McDonald, R.N., has been appointed superintendent of nurses at the New Liskeard and District Hospital, New Liskeard, Ont. A graduate of the Woodstock General Hospital, Miss McDonald completed a post graduate course in obstetrics at the Margaret Hague Maternity Hospital, Jersey City, N.J., returning to Woodstock for a two-year period as obstetrical supervisor and night supervisor. She spent one year at Moose Factory Indian Hospital gaining experience in tubercu-

(*Continued on page 22*)

Limited-Budget Buildings



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Notes About People

(Continued from page 18)

losis nursing and has for the past four years been supervisor of obstetrics in New Liskeard. She is replacing Betty MacKay who is taking a post graduate course in nursing at McGill University.

* * * *

Accepts Federal Post

After heading Saskatchewan's Hospital Services Plan almost since its inception in 1947, G. W. Myers, executive director, has resigned to accept the position of director of finance, purchasing and stores for the federal Department of Veterans Affairs at Ottawa. A graduate of the University of Saskatchewan, Mr. Myers first entered the provincial public service in 1937, serving with the provincial audit, treasury and highways departments before joining the health department. Since 1950 he has also been chairman of the departmental hospital rate board, which establishes the rates hospitals receive for care of hospitalization plan beneficiaries.

* * * *

Appointments at Hôpital Jean Talon

The board of administration has appointed Dr. J. L. Rochefort, formerly a governor of the Quebec Hospital Service Association, as medical director of Hôpital Jean Talon, Montreal, P.Q. At the same time Paul Emile Olivier has been appointed comptroller of the hospital, effective October 1st. Mr. Olivier was previously comptroller at Hôpital Ste. Jeanne d'Arc in Montreal.

The school for nursing assistants at Hôpital Jean Talon has opened and Jeanne Vincent has been appointed its director.

* * * *

Staff Changes at Victoria Hospital

The resignation, after 18 years' service, was announced recently of Viola M. Graham, superintendent of nurses at the Victoria Hospital, Renfrew, Ont. Miss Graham is resigning for health reasons. The resignation was also announced of Florence Wilkins, dietitian.

* * * *

Changes Position

Howard Smith, secretary treasurer of North Bay Civic Hospital, North Bay, Ont., has taken over as administrator of that hospital. He replaces R. J. Long who left to become administrator at Northwestern General Hospital, Toronto, Ont. This summer he successfully completed the first year of the two-year course in hospital organization and management sponsored by the Canadian Hospital Association.

* * * *

Matron at Crow's Nest Pass Municipal Hospital

Mrs. Constance Dunlop, R.N., has been appointed matron of the Crow's Nest Municipal Hospital, Blairmore, Alta., replacing Helen Clemis, R.N., who is at the University of Toronto. Mrs. Dunlop graduated from the Holy Cross Hospital in Calgary in 1929 and has had varied experience in the nursing profession.

* * * *

Appointment of New Medical Director

Dr. Marc Poulin has been appointed medical director of the Hôpital St-Joseph, Thetford Mines, P.Q. A graduate in medicine from Laval University in 1949, Dr. Poulin has recently returned from specialist studies in France and Switzerland.

* * * *

Appointment of Director of Nurses, Nanaimo

Mrs. Elizabeth Bucknell, late of the Kootenay Lake General Hospital, Nelson, B.C., has been appointed director of nurses at the Nanaimo General Hos-

(Continued on page 26)

ETHICON DIVISION OF Johnson-Johnson LIMITED, MONTREAL

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Notes About People

(Continued from page 22)

pital, Nanaimo, B.C. Mrs. Eileen Rodgers was appointed assistant director of nurses. Mrs. Bucknell came to Canada in 1953. A graduate of the North Middlesex Hospital, London, England, she has completed post-graduate courses in nursing administration, instruction, housekeeping and dietetics. Mrs. Bucknell has also previously held appointments in: Nice, France; London, England; Burma; the Territorial Service of the British East Africa Command; and the Mount Kenya Hospital, Nyeri, Kenya.

* * * *

Administrator of New Hospital

Peter Hodge of Terrace, B.C., has been appointed administrator of the new 60-bed unit, Maple Ridge Hospital, Haney, B.C. He has previously been with the Prince Rupert General Hospital and Terrace and District Hospital, B.C.

* * * *

Canada to Malaya

J. A. Willan, formerly consultant in hospital management, Department of National Health and Welfare, has been appointed to the World Health Organization, Geneva, in a similar capacity. He will spend two years in the Western Pacific Region of the W.H.O., advising the Government of Malaya on health management problems. His duties will include a review of the system of administration in that government's 67 hospitals; advising on the planning of non-medical hospital administration; and devising a scheme for the training of hospital administrators. — *News Bulletin, I.H.F.*

* * * *

New Pharmacy Scholarship

Love Chabak of Toronto, Ont., has been awarded the first Canadian Foundation for the Advancement of Pharmacy Fellowship for Hospital Pharmacy, a scholarship which will be awarded annually for post-graduate work in hospital pharmacy for one year. Miss Chabak has been on the staff of the Women's College Hospital, Toronto, since her graduation from the University of Toronto in 1953. She plans to intern for the year at St. Luke's Hospital, Cleveland, under Mrs. Evlyn Gray Scott.

* * * *

Medical Missionary

Jean Shepherd, R.N., has been appointed superintendent and secretary-treasurer of the Elizabeth M. Crowe Memorial Hospital, Eriksdale, Man. Miss Shepherd is a medical missionary under the Women's Missionary Society of the United Church of Canada.

- Don Tilden, of Point Pelee, was elected president of the Leamington District Hospital Board, Leamington, Ont., at a recent meeting. He succeeds Foster Jackson in the post.

- John E. Sullivan of Deerfield, Illinois, has been appointed to the new position of controller of the American Hospital Association.

- Edward W. Hawkins, Q.C., magistrate of Dauphin, has been elected chairman of the board of directors for the Dauphin General Hospital, Dauphin, Man. Mr. Hawkins has served on the board for ten years.

- Mrs. G. Graham has left Port Hope Hospital to become accountant at the recently enlarged Oakville-Trafalgar Memorial Hospital, Oakville, Ont.

- Sister St. Anthony, new administrator of St. Joseph's Hospital, Chatham,

(Concluded on page 118)

W. Douglas Piercey, M.D., Editor

The Canadian Hospital

Obiter Dicta

Confidence Should Be Mutual

AT A recent hospital meeting the question was asked: "What can be done to develop a stronger feeling of confidence in directors of nursing towards administrators and governing boards?"

We believe the phrasing of this question puts the emphasis in the wrong place because just as certainly as the administrator must have the confidence of his board so the director of nursing must have the confidence of the administrator. As far as the administrator and the director of nursing are concerned we believe that the confidence should be mutual. The question is far from being academic and has practical application for many hospitals in their day-to-day work. This question possibly was asked by the superintendent of a small or medium-sized hospital, where a man is the administrator, the hospital not very departmentalized, and where the director of nursing has duties apart from the nursing service, possibly with relation to housekeeping, and the dietary department.

We have said on many occasions that there can be but one administrative head of a hospital. Sometimes lack of confidence has been engendered by the board itself, in that they have encouraged, perhaps unwittingly, or at times deliberately, an administrative pattern in the institution where there is actually dual control. We are thinking primarily of hospitals where the administrator is a lay person and is responsible to the board for the business functions. In this type of organization the director of nursing is responsible for many of the professional aspects of hospital service and her duties may include direction in areas where departmental heads have not been appointed.

Where mutual lack of confidence exists, often the trouble is that the administrative control of the hospital has not been clearly defined. Here the first step required is that the by-laws and regulations should state in very clear terms the duties of the chief executive officer and the director of nursing. In many hospitals there is misunderstanding of what constitutes a matter of over-all hospital policy — requiring board decision — and what is an administrative matter — and hence should be handled by the chief executive officer. Too often we find the triangle of administrator, director of nursing, and individual board members, all having their fingers in the administrative pie. It will be an exceptional hospital which operates smoothly under these conditions.

Assuming one chief executive officer is recognized by the board and the administrative organization is clearly defined, then the position of the director of nursing is quite clear. She is responsible for the nursing function of the hospital and whatever other areas are designated to her. At the time of her appointment those matters which she is expected to refer to the administrator should be defined. He will require certain reports on a daily, weekly, monthly and yearly basis, and the director of nursing should have ample opportunity to confer regularly with him to discuss matters where she needs advice; and she should be kept informed of all general hospital policies relating to her department. One thing that must not be

overlooked is that she has to be given sufficient authority to cover her responsibilities in the areas designated to her. The administrator should not look over her shoulder continually and meddle in the detailed running of her department.

Confidence of the director of nursing in the administrator cannot be demanded and obtained by a written directive. It is engendered by respect and this is a two-way road. If any administrator is aware that there is a need for a stronger feeling of confidence on the part of his director of nursing towards himself and the governing board, then there must be mutual co-operation and the spirit of give and take. To gain this confidence, several attributes are necessary in the administrator himself. Certainly one is truthfulness; some others are frankness, tact and the willingness to co-operate. Often confidence is worn down slowly over a period of time by thoughtlessness. It may be many little things which build up from day to day. If the administrator wants a stronger feeling of confidence from his director of nursing, then he must show confidence in her.

Being director of nursing of a hospital, be it large or small, is not an easy vocation. To be successful it calls for great responsibility, ingenuity, long hours, and hard work. She is frequently the target for unjustified criticism on the part of some of her own staff, the medical staff, and the rank and file of other departments. To be successful she must have the complete support of her superior officer. Those cases where she has the unqualified support or where it is obvious that she has no support are undoubtedly in the minority. Most cases would fit somewhere in between, where the word "unqualified" would have to be changed to "partial". Where the director of nursing has reason to believe that she has the partial support only of her administrator, then one cannot expect that she will have complete confidence in him. This does not mean that the director of nursing should expect that every idea she brings forward will be accepted by the administrator and through him by the board. What she should expect is that they will have adequate time to discuss their department policies with the administrator—and as necessary with board committees. When a course of action has been agreed upon, she should be backed by the administrator to all and sundry—be it the governing board, the medical staff, personnel in her own department or other parts of the hospital.

The gaining of a person's confidence is something that we have to earn. Those administrators who are worried lest their directors of nursing do not have confidence in them should give thought to whether or not there is anything wrong in their own handling of people in general, and the director of nursing in particular, which would lead to this state of affairs. If after self-examination they are certain that the fault does not lie with themselves, then if they really are administrators, they will see to it that they obtain the services of a director of nursing with whom they can work harmoniously and with mutual confidence.

St. Boniface Hospital

On Tuesday, May 17th, 1955, a new milestone in the story of St. Boniface Hospital, St. Boniface, Man., was passed. On that day, the institution officially opened its new nine-storey wing and nurses' residence. In a much enlarged and fully modernized physical plant, the hospital continues to serve citizens of Manitoba as it has done continually for more than three-quarters of a century.

The four sisters of charity who left Montreal in 1844 on their hazardous trip into the western wilderness—to the St. Boniface mission some 2,000 long miles away—could not possibly foresee the results in our day of their journey. To reach their destination the sisters had to travel the entire distance by canoe, along the route of the old fur traders. For 59 days, during which 78 portages were made, sometimes in blistering sunshine, often in heavy rain storms, frequently in placid water but often through swirling rapids, they forged ahead reaching their destination at one o'clock in the morning when the countryside was bathed in bright moonlight.

For 27 years the sisters laboured without a hospital. They visited the sick in their homes, going by Red River cart to those living at a distance. The first hospital was completed in 1871; it had accommodation for 4 patients. From that small beginning, the hospital has continued to grow throughout the years, extending its service with the growth in population of the province of Manitoba.

In this issue we publish ten articles portraying various features of the new addition along with floor plans and pictorial views. We are indebted to Sister Jarbeau, Superior and general administrator, who arranged this series and to members of her staff who prepared the articles for us. They tell the story of St. Boniface Hospital today and how it is meeting the challenge of extended service in that part of Canada which is known as the "gateway to the west".

Hôpital St-Boniface

LE MARDI, 17 mai, 1955, a marqué la fin d'un autre chapitre dans l'histoire de l'hôpital St-Boniface, à St-Boniface au Manitoba. Ce jour-là, l'institution a inauguré officiellement sa résidence d'infirmières et son aile nouvelle comprenant neuf étages. Dans un bâtiment beaucoup élargi et complètement modernisé, l'hôpital continue à servir la population du Manitoba, comme il l'a fait constamment durant plus de trois-quarts de siècle.

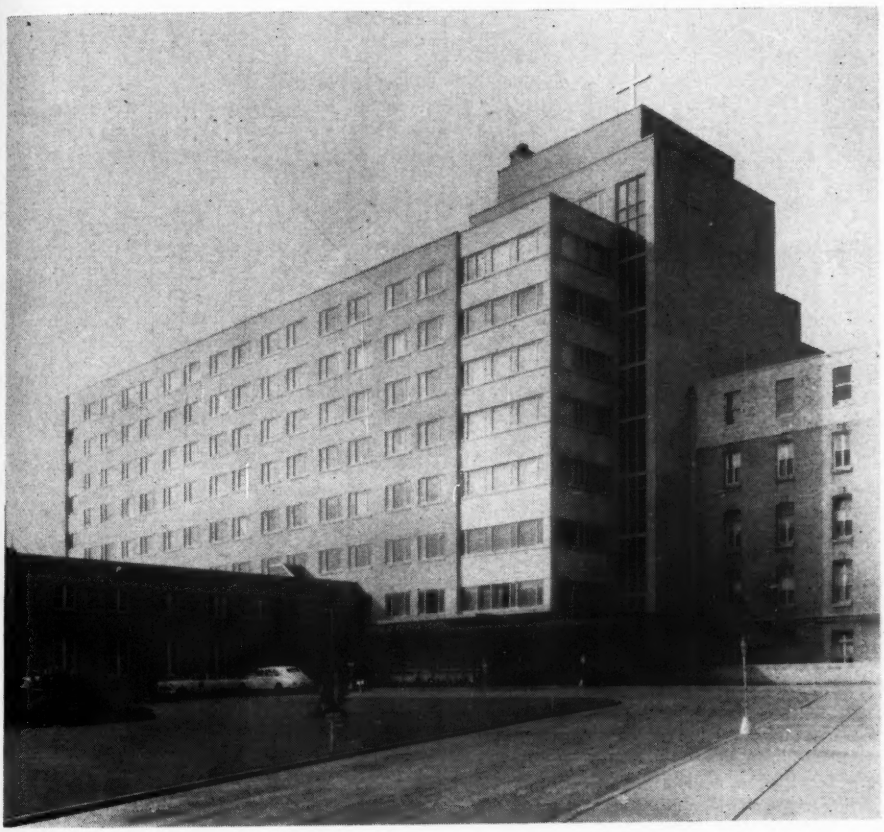
Les quatre soeurs de charité, qui quittèrent Montréal en 1844 pour faire un voyage hasardeux dans les lieux déserts de l'ouest jusqu'à la mission de St-Boniface—éloignée de quelques 2,000 milles, — ne pouvaient guère prévoir les conséquences de leur voyage. Elles devaient parcourir toute la distance par canot, suivant la route des anciens commerçants en pelleterie. Pendant 59 jours elles ont continué d'avancer, faisant 78 portages, parfois par un soleil brulant, souvent dans une pluie battante, fréquemment sur des eaux placides mais souvent à travers des rapides tourbillonnants, et elles sont arrivées à leur destination à une heure du matin, pour voir le pays au clair de lune.

Pendant 27 années, les soeurs travaillèrent sans hôpital. Elles visitaient les malades à leurs demeures, se rendant par charrette "Red River" chez ceux qui habitaient à une grande distance. La construction du premier hôpital était finie en 1871; il logeait 4 patients. A partir de ce modeste début, l'hôpital a continué à s'étendre au cours des années, augmentant ses services à mesure qu'augmentait la population de la province de Manitoba.

Dans cette édition nous publions dix articles qui dépeignent des aspects variés de la nouvelle addition, accompagnés par des plans et des photographies. Nous sommes reconnaissants à Soeur Jarbeau, supérieure et administratrice en chef qui a arrangé cette série, et aux membres de son personnel qui ont rédigé les articles. Ils racontent l'histoire de l'hôpital St-Boniface jusqu'a nos jours et la manière dont il fait face à l'appel d'un service plus étendu dans cette partie du Canada que l'on appelle la "porte de l'ouest".

St. Boniface Hospital

enlarged and fully modernized



Hospital Main Entrance, showing new wing.

MORE than a century ago, in 1844, four Grey Nuns from the Order of the Sisters of Charity in Montreal arrived in St. Boniface to inaugurate in that community a health service which has continued to grow ever since. After 27 years of home nursing this Order opened a pioneer hospital in the Canadian West — a four-bed hospital which received its first patient in 1871.

From this humble beginning, inspired always by its motto *Caritas Christi urget nos,* the hospital has developed and expanded in step with the needs of this rapidly growing centre of the great western plains. An expansion to 10 beds took place in 1877 and this was replaced by the first wing of the present structure in 1887. After ten years a second wing was opened, and a third a few years later. An out-patient treatment centre was built in 1928.

In 1897 the first school of nursing was opened and the initial class of three nurses graduated in 1899. The 58th class of 73 nurses will graduate this year from a recently completed addition to the school which furnishes the most up-to-date accommodation for 300 students.

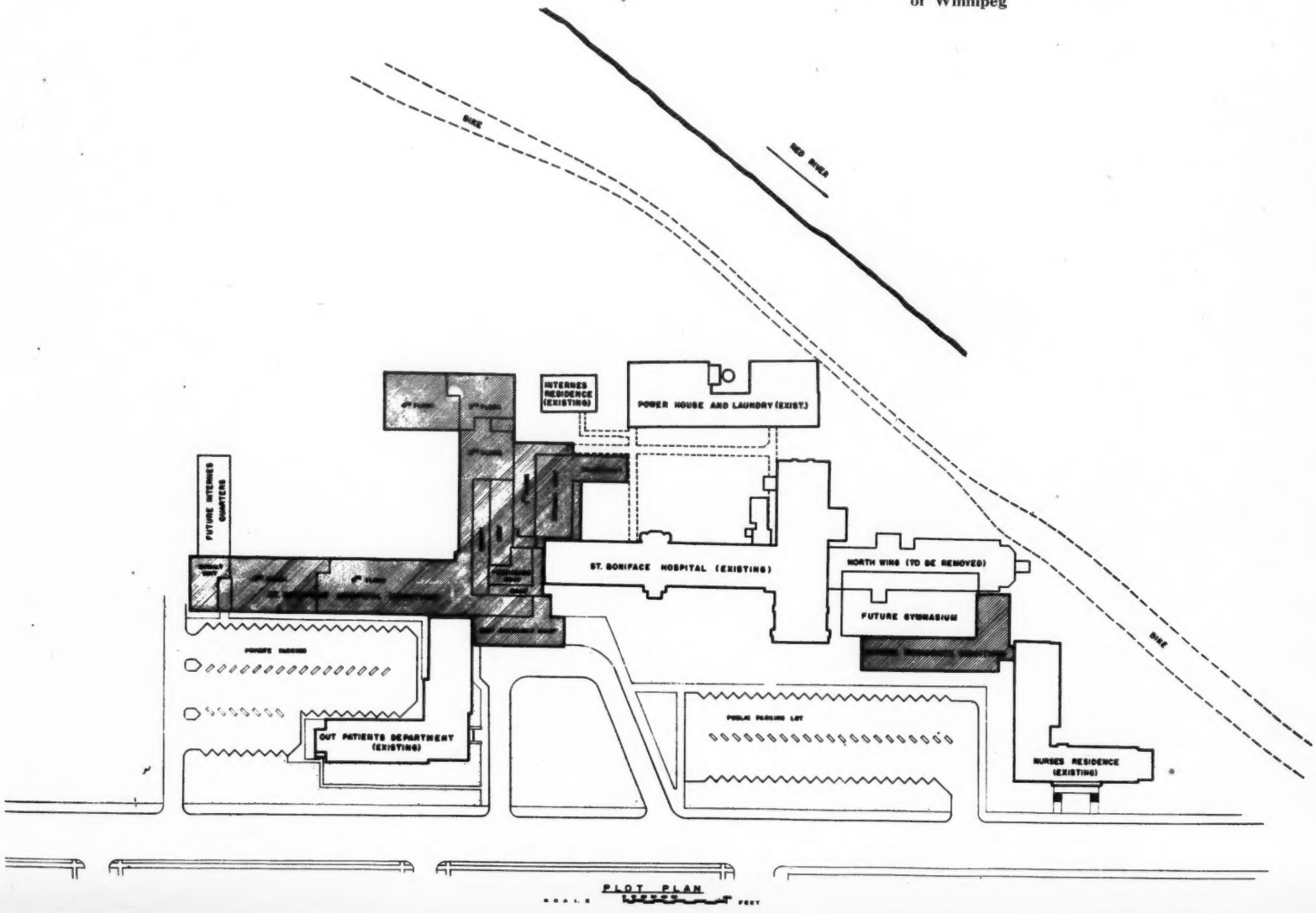
The latest addition to the hospital is a modern nine-storey building which includes all services, and, together with the completely remodelled older buildings, will bring the complement of fully equipped modernized beds to 670 and 60 bassinets.

Men, women, and children from all walks of life have, in the past, sought aid and comfort at this hospital — more than a million of them in the 85 years it has stood forth as a beacon for those who needed care. Over 28,000 list St. Boniface Hospital as their place of birth. In those 85 years St. Boniface Hospital maintained its true course of service and devotion to mankind, giving hope and health to the sick and the injured, regardless of race, colour, religion, or ability to pay.

St. Boniface Hospital is approved by the Canadian Medical Association for the training of interns, and by the Royal College of Physicians and Surgeons for advanced post-graduate

In this series the names of authors appear at the end of each section.

Architects :
Green, Blankstein, Russell & Associates,
of Winnipeg



PLOT PLAN

training. The school of nursing is approved by the Manitoba Association of Registered Nurses. In 1942, the school for x-ray technicians was approved by the American Registry of X-Ray Technicians, and in 1943, the school of medical technology was approved by the Canadian Medical Association. The hospital is a member of the Associated Hospitals of Manitoba, the American Hospital Association and the Catholic Hospital Association of the United States and Canada.

While retaining its beautiful tradition of charity and devotion to the sick, St. Boniface Hospital — completely modernized in physical facilities, in medical and surgical equipment and in internal organization — looks forward to a new era of service to the public. It has a professional staff composed of specialists in the different branches of medicine. The standard of service which has been maintained in this hospital for over three quarters of a century, has enabled it to retain its place among leading hospitals in Canada. — *Sr. R. Veilleux, S.G.M.*

Planning

THE planning of the new St. Boniface Hospital was made feasible by the fact that the hospital authorities had ample property to the south of the existing buildings. Another factor in the planning was the position of the two-storey and basement outpatient building situated some eighty feet to the south east of the existing buildings.

The new building was planned in the shape of an L with the main entrance and elevator core at the angle. With one bar of the L placed against the end of the existing hospital and the other against the end of the outpatient building, the plan of the combined buildings at the basement, first, and second floor levels is approximately cruciform in shape with the elevators at the crossing. From the third to the fifth floors inclusive the plan of the new and old hospital buildings is in the form of a T. Above that the new building is, of course, an L.

This made possible a favourable arrangement of the various departments with respect to the elevators and to each other. For instance, for the convenience of the doctors and staff, surgery, recovery, x-ray, and laboratory divisions were all accommodated on the second floor.

The main floor level of the existing building, and hence of the new building also, is about eight feet above the street. As the building was set well back it was possible to build an earth ramp up to the main entrance, thus avoiding steps.

Somewhat unusual is the position of the ambulance entrance, adjacent to —but separate from — the main lobby. This makes the one admitting office convenient for all incoming patients whether they arrive by ambulance or through the main lobby.

The new building is completely air-conditioned. Special departments such as the laboratory, operating rooms and the kitchen have their own low pressure systems. The nursing floors and offices are served by a high pressure system.

The central and south wings of the original hospital building are presently being modernized to give the accommodation as listed below. Patient areas in this building will also be air-conditioned. The north wing will be demolished as it is unsuitable for rehabilitation.

An addition has been built to the school of nursing, adding to the accommodation 84 single rooms, together with library, offices, lecture and demonstration rooms. Provision has been made for the further addition of a gymnasium and auditorium when funds are available.

The architects for the new buildings were Green, Blankstein, Russell and Associates, of Winnipeg. The contractors were Commonwealth Construction Company Ltd.; except for the addition to the School of Nursing which was built by Couture and Toupin. — *G. L. Russel, B. Arch.*

Medical Records

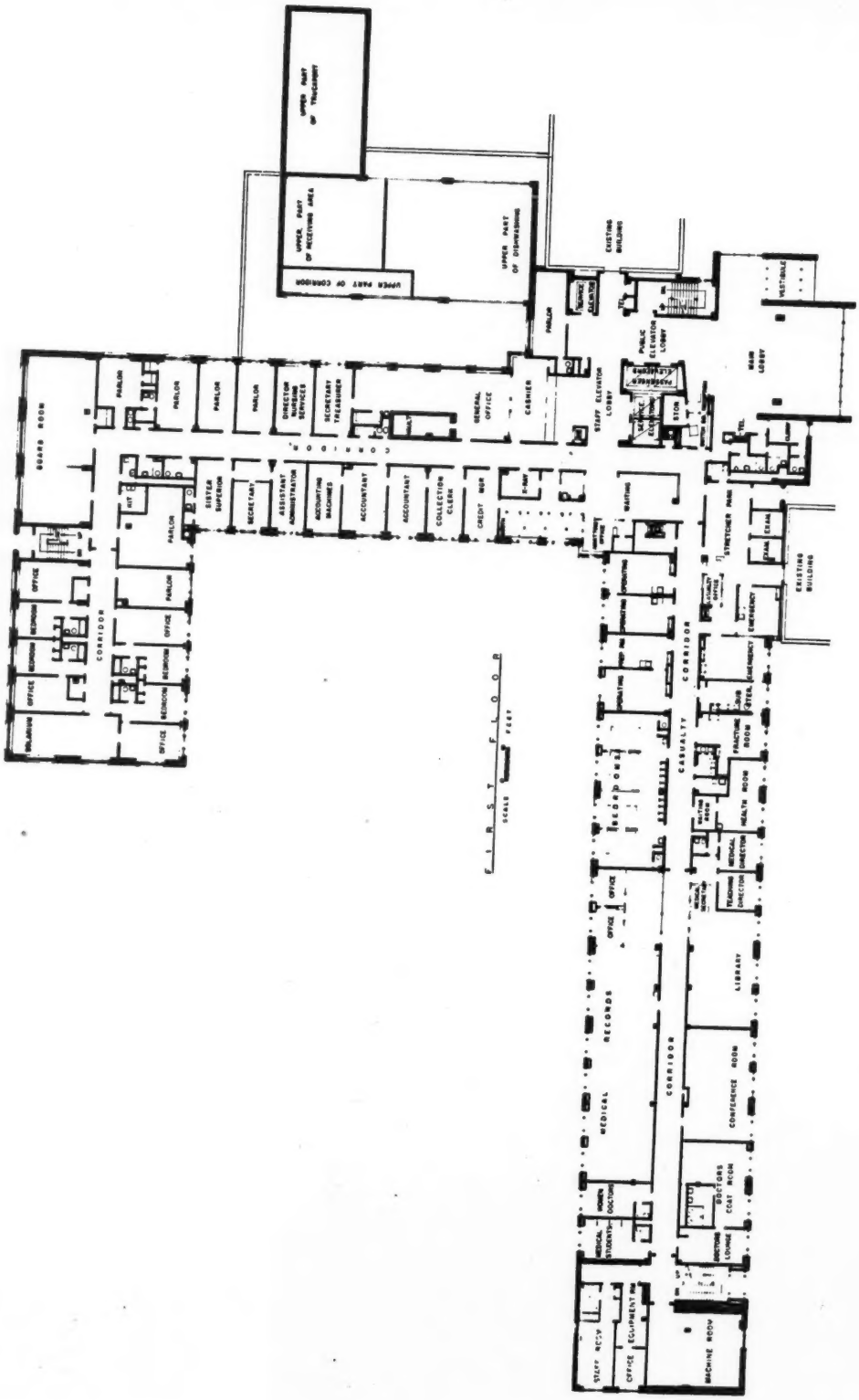
THE medical records department is located on the main floor of the south wing. The medical director's office with adjoining medical library, the physicians' lounge and the emergency department are located in the same wing. The department is conveniently accessible to physicians when entering and leaving the hospital as there is a special doctors' entrance at the south end of the wing which gives them direct access to their car park. This central location of the department facilitates the writing, signing and using of records, as well as accessibility to the administrative area. The admitting, information and switchboard, business and administrative offices are located in a different wing on the same floor.

The total area of 1,900 square feet provides sufficient space for proper arrangement for effective work performance. The department consists of one large room divided into four areas, storage, clerical, office, and physicians' workroom.

The storage area occupies approximately 500 square feet of space and is at the south end of the section. It contains vertical steel filing cabinets sufficient for five years housing of current charts. The clerical area is in the middle section and ample footage has been allocated to provide a comfortable working arrangement. The nine clerical employees of the department are under the direction of a medical record librarian. A U-shaped flow of work has been employed.

The clerical area is terminated by a laminated plastic counter—the point of service to professional personnel. A pneumatic tube has been installed at the "wall" end of the counter. The tube speeds up the remittance of loose reports to the department. A small file cabinet has been conveniently placed on the counter. The cabinet contains

Medical Records Room.


FIRST FLOOR
SCALE
BOARD ROOM
PARLOR
CORRIDOR
OFFICE
BEDROOM
SISTER SUPERIOR
SECRETARY
ASSISTANT ADMINISTRATOR
ACCOUNTING MACHINES
ACCOUNTANT
COLLECTION CLERK
CREDIT MGR
DIRECTOR NURSING SERVICES
SECRETARY TREASURER
GENERAL OFFICE
CASHIER
STAFF ELEVATOR LOBBY
PUBLIC ELEVATOR LOBBY
MAIN LOBBY
VESTIBULE
EXISTING BUILDING
UPPER PART OF RECEIVING AREA
UPPER PART OF DISHWASHING
UPPER PART OF CORRIDOR
UPPER PART OF TRUCKWAY
WAITING
STRETCHER PARK
EXAM.
CASUALTY
EMERGENCY
FRACTURE ROOM
PLASTER ROOM
HEALTH ROOM
TREATING ROOM
MEDICAL DIRECTOR
RECORDS
MEDICAL
LIBRARY
CONFERENCE ROOM
DOCTORS COAT ROOM
DOCTORS LOUNGE
MACHINE ROOM
STAFF ROOM
OFFICE EQUIPMENT

mail and messages for the doctors and acts as a distribution point for remitting information to doctors. This has aided in making the department the medical focal point of the hospital.

The entrance to the department is a few feet to the north of the counter. Opposite the entrance is the office area which consists of two glass-partitioned offices. One is for the medical record librarian and the other office is used by the doctors for research purposes. The physician's work area consists of a laminated plastic counter located at the north end of the room adjacent to the offices. Doctors and interns complete their charts in this quiet space.

Other impressive features of the department are the amount of natural lighting and air-conditioning. Eight picture windows, size eight feet by six, provide excellent natural illumination. The air-conditioning unit is set for a year-round temperature of seventy degrees. These features aid in providing agreeable working conditions. Light oak furniture contributes to the brightness of the room.

A storage room for old records is located in the semi-basement of the new hospital. This room is ideal for storage because it is close to the department and has ample space.

The services of the department include the assembling and completion of the patient's record, a quantitative analysis of all records, the collection of statistical data from the records for various medical and administrative reports, the indexing of records, and maintaining property rights of the records. The indexes consist of a code index, diseases and operation indexes and patients' index. The code index is maintained for the medical audit.

The monthly reports include an analysis of hospital services, midnight census, and various reports for medical staff departments. The analysis of hospital services is a statistical resumé of the professional work performed in the hospital. The midnight census serves as a check on admissions and discharges and forms the basis for calculating the monthly percentage of occupancy for each ward. Other records are also maintained for the obstetric department and other service departments.

The medical director administers a continuous medical audit. This procedure involves the co-operation of the medical record librarian, tissue committee and medical staff. The system has proved to be satisfactory both to the administration and to the physicians.

The lay-out of the medical records department has provided for a smooth flow of work and has resulted in a closer liaison between the department and the physicians. — *Miss L. Bowdler*

The Medical Library

THE visiting surgeon stood in the doorway of the medical library, in the new addition to the hospital. "Well", he remarked to the librarian, "if a man couldn't study in here, I don't know where he could". In so saying, he summed up the expressions of several thousand people who have visited the new library.

Experience has shown that it is a considerable achievement to make a reading room comfortable, without inducing a desire for rest or ease. It would seem that those who planned the physical appearance and reading comfort of the hospital's library actually accomplished this feat.

On entering the forty-by-twenty foot reading room, the visitor is first attracted by three large picture windows, facing east, equipped with softly-designed drapes to curb the brillance of the morning sun. Parallel to these windows are two rows of polished birch tables, whose dimensions (five and a half by three feet) allow ample room for two readers at a time. These tables, built to the hospital's specifications by specialized craftsmen, are solidly heavy in traditional library style. They are matched by chairs which combine posture and comfort to the utmost degree. All furniture is of matching birch.

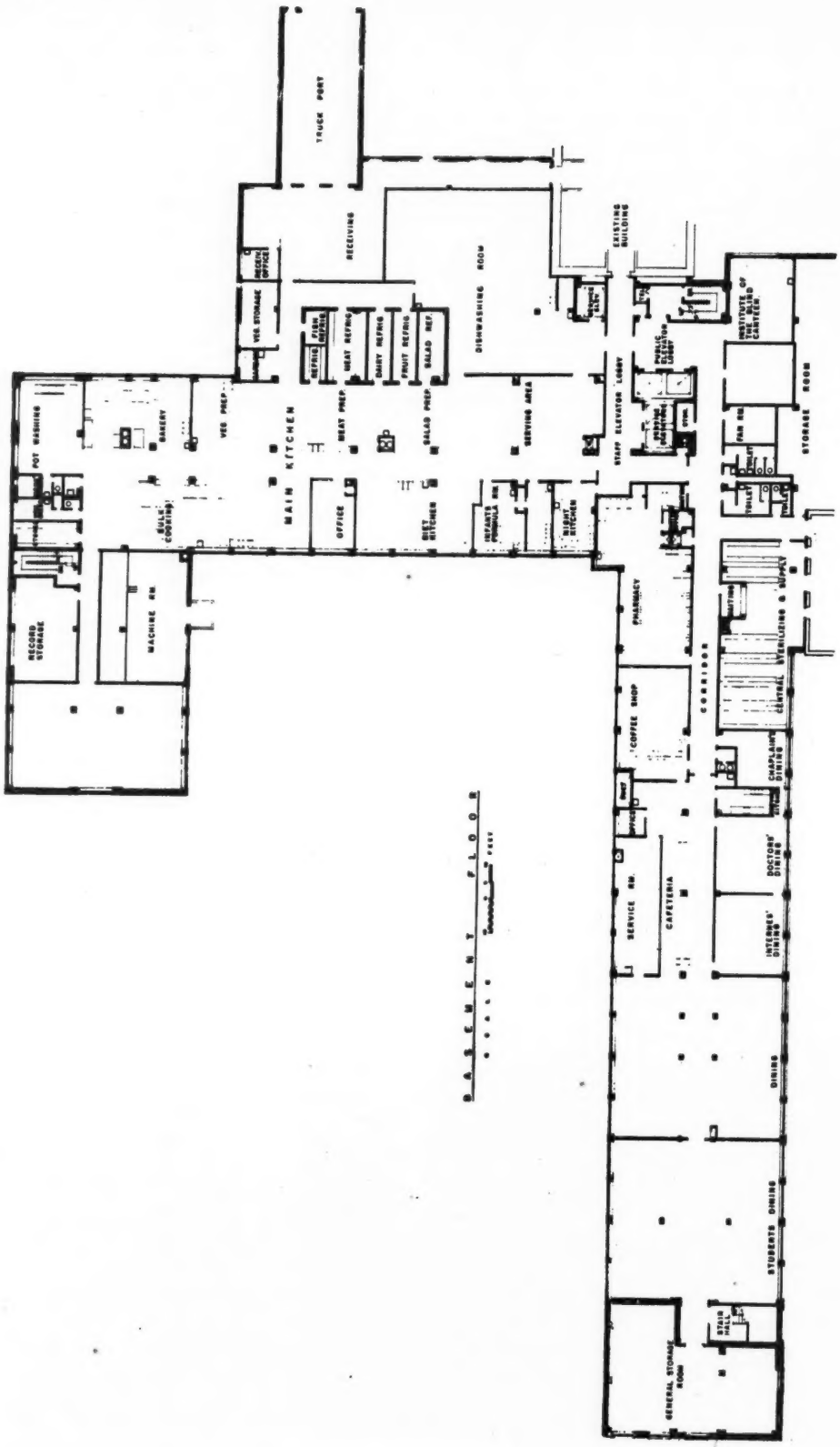
On the south wall, the book shelves range to a height of seven feet and contain textbooks and bound periodicals. The books are arranged under the classification of the Library of Congress. This was specially planned for the quick selection and convenience of interns and medical students who have used this arrangement of books and journals all through their years at medical college.

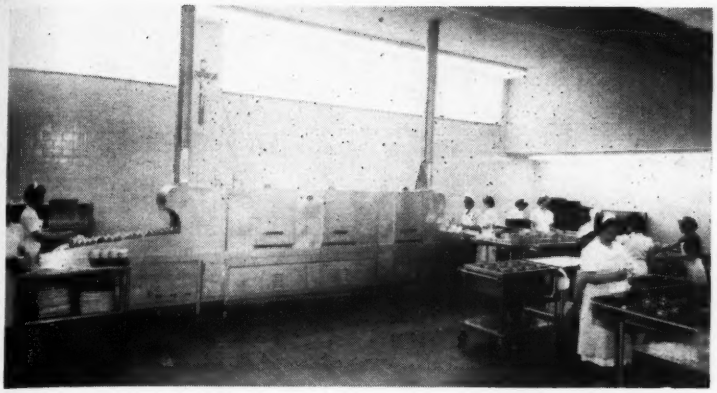
Also following the plan usually accepted by medical colleges is the journal rack on the west wall. This attractive structure is six feet long, with adjustable shelves on which are sixty-three medical periodicals, alphabetically arranged according to specialty. From the top downwards, the alternate rows are almost upright, to allow the current issue of each periodical to stand up prominently. Below each standing journal is a flat shelf on which is piled the previous issues.

An experienced librarian is on full-time duty, working under the supervision of the medical director, and in liaison with the library committee, whose members are chosen from the medical and surgical staffs. Besides the usual duties of a librarian, she assists readers in locating specific articles and chapters for use in preparing papers, arranges inter-library loans with other hospitals and university libraries, and reads as many as possible of the incoming journals in order to recommend outstanding articles to readers in their particular specialties. — *Miss L. Bowdler.*

The medical library for students, interns and doctors.

St. Boniface . . . . .


TRUCK PORT
RECEIVING
DISHWASHING ROOM
EXISTING BUILDING
MAIN KITCHEN
BAKERY
VEG PREP
MEAT PREP
SALAD PREP
SERVING AREA
OFFICE
DIET KITCHEN
POT WASHING
RECORD STORAGE
MACHINE RM
STAFF ELEVATOR LOBBY
PHARMACY
COFFEE SHOP
CAFETERIA
SERVICE RM
CHAPLAINS' DINING
DOCTORS' DINING
INTERNES' DINING
STUDENTS' DINING
STORAGE ROOM
GENERAL STORAGE ROOM
BASEMENT FLOOR



The dish-washing department.

Food Service

FOOD service is a vital activity in any hospital. It acts both as a therapeutic measure aimed at a specific disease condition and for the general welfare of the patient and the employee. Indirectly it is an important public relations medium because of the effects that food and its service exert on patient and employee morale. These factors were the prime considerations taken into account when the dietary department was being designed.

The principle of structural simplicity based on function was adopted in planning the department. It was designed so as to save steps and avoid the confusion of cross traffic. Thus work in the kitchen proceeds in an orderly manner from the receiving area to storage, thence to pre-preparation, preparation, service, consumption, and disposal of waste.

The kitchen is in the semi-basement, a central location chosen because of easy accessibility to the receiving area, cafeteria and nursing units.

The food service department is of an "open-type" construction with the following areas semi-partitioned: bulk-cooking, baking, salad preparation, meat preparation, central tray service, diet kitchen, dietitians' offices, and washing up area. The supervisor's office, lunch room, and two formula rooms are glass-partitioned. This layout provides enhanced natural lighting, simplifies supervision, and saves space. There will be fewer walls to wash and corners to clean. Dishwashing apparatus, the garbage disposal unit, and the storage areas, are contained in their respective compartments.

Walls of creamy tile, floors of red quarry tile, and gleaming stainless steel add a cheerful appearance to the department. An air-conditioning unit keeps the kitchen cool during the warm summer weather and free from odours. An intercom connecting all areas in the department and connecting the supervisor's office in the kitchen with that in the cafeteria helps to speed kitchen work.

The cafeteria and coffee shop are located at the south end of the semi-basement. The former is divided into three main sections: dining areas for student nurses, for staff, and a special dining area. The latter includes a sliding wall to enable two separate groups with speakers to use each segment of the room at the same time. Decor of the cafeteria is pale green, including floor tile and drapes.

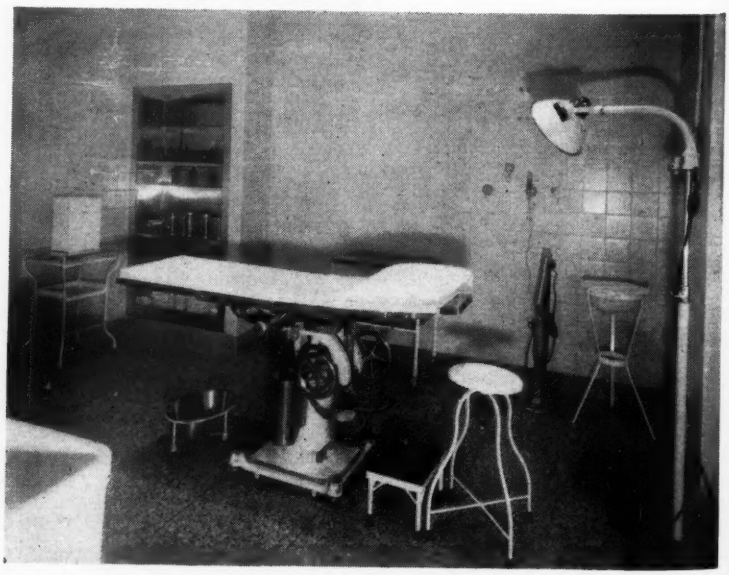
A master menu method, whereby the food is purchased, prepared, and served according to one pattern for all nursing units and for the cafeteria, has been adopted. The reasons for selecting this method were to improve the quality of the food and to serve it in a more palatable, nutritious, and economic manner.

Early in the designing of the new hospital, it was decided to adopt a modified centralized type of patients' food service, using food tray carts to distribute the patients' meals. This type of service was selected to permit more effective control of amounts served, supervision for making trays

The diet kitchen.

The admitting department, showing waiting room, interview cubicles and duplicating room.

Main Lobby



One of four emergency operating rooms located on first floor near ambulance entrance.

more attractive, and inspection of each serving to make possible a higher level of food service.

The modification in the centralized food service consisted of installing separate assembling areas for general and for special diets. This modification was chosen to save time. A quick reference to the diagram of the kitchen will show that the areas are located in proximity to each other and to a kitchen service elevator which may be used only by the kitchen employees. Food is delivered in bulk to the isolation ward and the personnel on the ward prepare and deliver the trays.

Inspection of the general diets preparation is the responsibility of the dietary services supervisor. An assembly line on an electric conveyor belt produces 11 trays per minute. The completed trays are delivered in loads of 14 trays per cart (the unheated type). The tray carts are taken via the kitchen service elevator to the nurses station. Head nurses are contacted and at this point the nursing staff assume the responsibility for the quick and effective serving of the trays. There is a mean delivery time of 14 trays per 2 to 4 minutes.

The supervision and inspection of the assembling of special diets is performed by two dietitians. Completed trays are assembled on a gravity roller conveyor. When the carts are loaded they are distributed in the same manner as the carts for the general diets.

In addition to providing high quality food and service to patients and staff, the dietary department assumes due responsibility for formal and informal education. The department instructs patients in proper dietary habits and participates in the student nurses program.

Dietetics is included in the nursing program to impress upon the mind of the student the relation of nutrition to health and disease and the importance of food in restoring patient health. A knowledge, appreciation and skill in the use of foods should give the student nurse an incentive in maintaining her own health as well as promoting that of her patients.

Future plans of the dietary department in this teaching hospital include the provision of an improved course for dietetic interns.

After a year in the new department, routines have been established and higher standards attained in the provision of "quality food, service, and education" to patients and staff by utilization of the highest dietary principles. —*L. A. Quaglia, B.A., B.Com.*

Laboratory

THE design and construction of the laboratory was based on the principle of efficiency — to attain which the following points were kept in mind:

1. There should be ready access to patients by the laboratory staff.
2. There should be a minimum of walking between laboratory and patients.
3. The layout of the individual departments should be such as to produce an even flow of work by the laboratory staff.
4. Working comfort should be given serious consideration. To this end, adequate lighting, air-conditioning and noise reduction by acoustic tile ceilings assist in improving efficiency of laboratory staff.

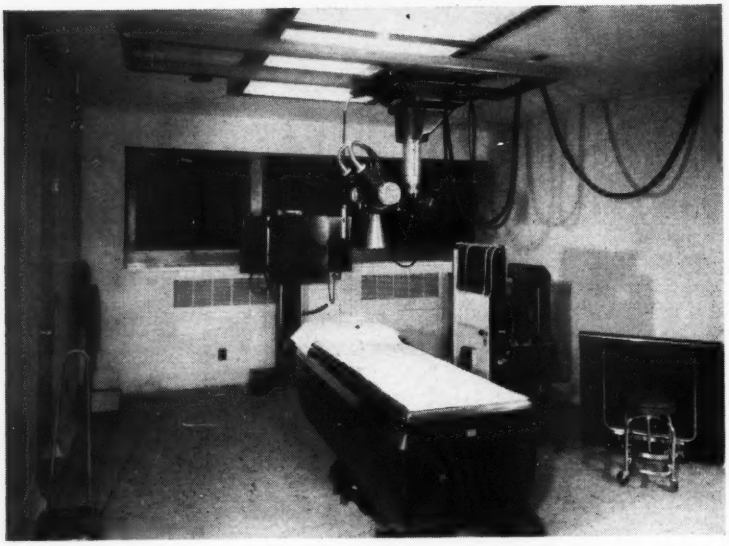
With regard to the above points, the laboratory is located on the second floor adjacent to the operating rooms and the x-ray department. A bank of four elevators at the entrance to the laboratory carries technicians to all hospital levels. The out-door department is located below it, so that outpatients requiring tests have ready access to waiting-room facilities in the laboratory.

The laboratory is L shaped, with arms of equal length. The portion closest to the elevators is given over to technical procedures to reduce the distance walked by technicians. In the far wing, the space has been devoted to histological procedures, clerical staff and pathologists' offices B.M.R., E.C.G. and photographic procedures are also performed in this wing, since it is quieter than the closer wing.

The individual departments were designed to produce as much countertop space as possible, with a fair allotment available for storage of chemicals, glassware, et cetera. The "peninsula" type of laboratory bench was used. All the laboratory furniture is of the "unitized" type so that change in function and alteration of laboratory benches is not a formidable procedure. Intercommunication systems between departments and the general laboratory office facilitate transmission of results to wards and provide information on the progress of procedures.

In the arrangement of laboratory furniture, the department was divided into functional units. Definite laboratory procedures were planned for specific areas and the equipment necessary for such procedures installed. The

The main biochemistry laboratory.



One of the diagnostic x-ray rooms showing ceiling-mounted unit.

commoner procedures had priority over the more uncommon, although space was allotted for the latter. Areas where writing and recording of results could be performed were located centrally.

Finally, to improve the accuracy and efficiency of the tests performed in the departments, acoustic tile was used throughout the laboratory, air-conditioning was installed and abundant fluorescent lighting placed over every work bench. The pathologists and technicians are well pleased with the final result and look forward to many productive years of work. — *F. Burgoyne, M.D., Path. Cert. (C), F.A.C.P.*

X-Ray Department

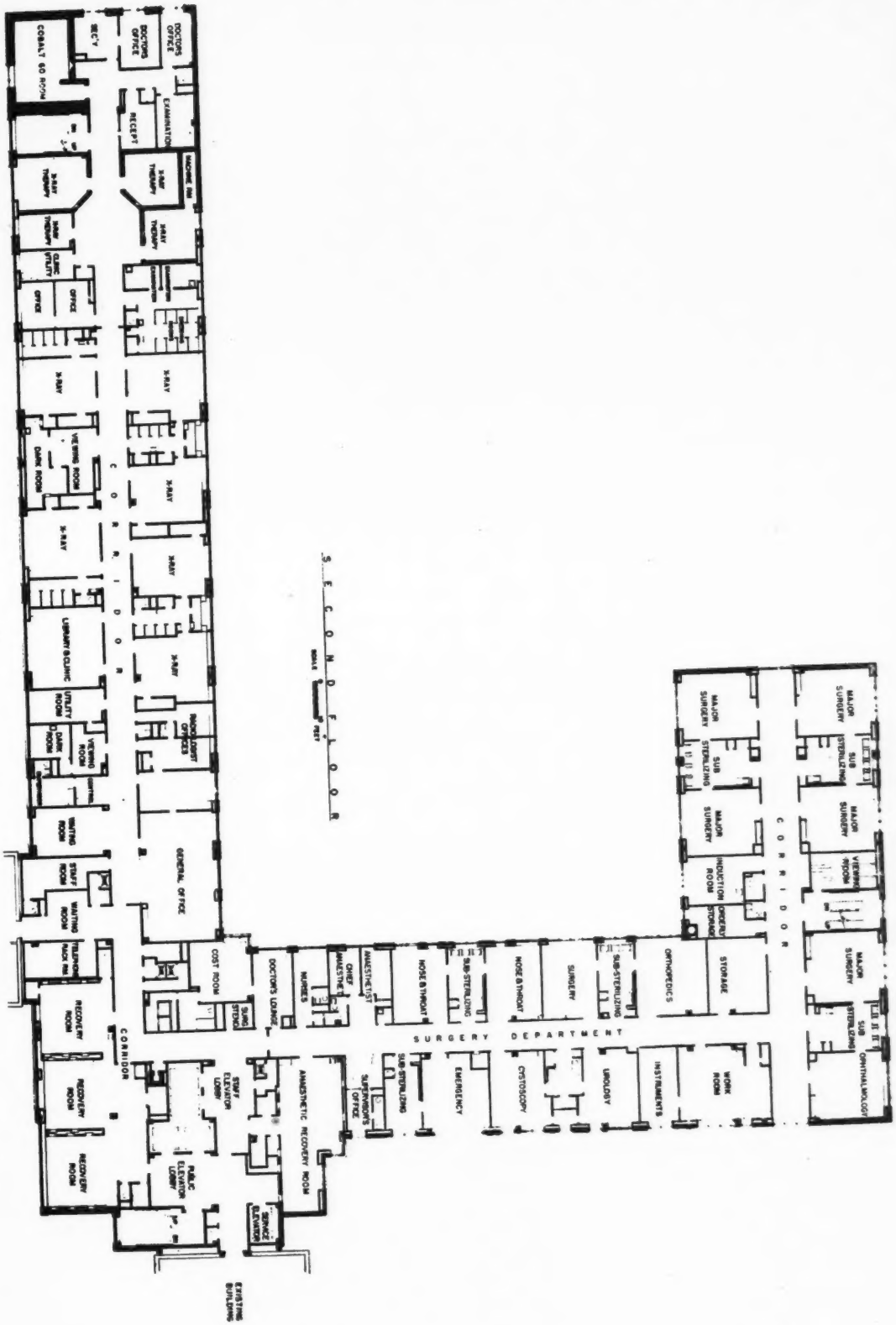
THE department of x-ray diagnosis occupies an extremely favourable location in the hospital. It is situated in the south wing on the second floor of the hospital. Entrance is from the central rotunda which contains the four main elevators. The operating theatres and the department of anaesthesia extend to the west wing from this central area, while the departments of pathology and biochemistry open into this space from the east wing. The department of x-ray therapy is situated also in the south wing, as a continuation of the diagnostic department.

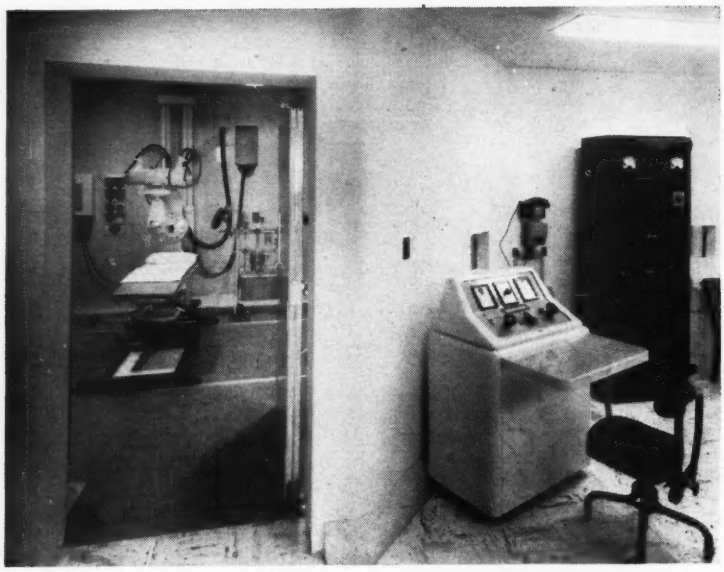
Possibly the most direct way to describe the physical set-up would be to start at the entrance, and briefly outline the rooms on the west side of the corridor, and then the rooms on the east side.

The first area encountered on the right-hand or west side as one enters the department is the general office with desks for three stenographers and an information counter. Next to this is the film room, with sufficient space for x-ray films for five years — a portion of this room is also used for sorting current films. Next is the viewing room, with a bank of sixteen viewing boxes, desks and stereoscope. This is so arranged that two radiologists may examine and report films at the same time without inconvenience. A small washroom is interposed between this room and the next, which is the radiologists' office. Following this is the first examining room, which contains a 200 ma. x-ray generator with vertical control and an R.33 table for fluoroscopy and radiography. There is also an upright chest stand in this room. On one wall is a dental unit, mounted with full angulation. Rapid and accurate positioning may be obtained with this unit. Next is the second examining room and this contains a 500 m.a. high KV x-ray generator, with V9 electronic control. Full photo-timing is available on this machine. The x-ray table has dual angulation speed from 90 degrees vertical to 90 degrees Trendelenburg, and is particularly useful for myelographic studies. Spot-film device accommodates 8 x 10, and 10 x 12 cassettes for serial exposures, or a 14 x 14 cassette for single film in chest or abdominal examinations. In conjunction with this unit is the film-changer with electronic contactor for rapid serial radiography up to speeds of 12 films per second, in lateral and A.P. planes simultaneously — each plane powered by 500 ma. high Kv. generator and x-ray tube. A program selector permits setting up film speed and sequence over three separate periods. This unit is used for cerebral angiography and angiocardiography. There is also a fluoroscopic arrangement on this machine which is of considerable value in cardiac catheterization. Examining room 3 is equipped with a 500 ma. high Kv. generator wtih B9 electronic control and complete photo-timing. A flat Bucky table is equipped for photo-timing on automatic reciprocating Bucky. The ceiling-mounted tube stand is similar to that in rooms 4 and 5. A craniograph also occupies this room, and provides precision facilities for rapid and accurate skull radiography. This is also powered by a 500 ma. generator.

Between rooms 3 and 4 is an area containing dressing cubicles, together with two washrooms and a separate stencilling room for films. Radiographic room 4 is used chiefly for barium examinations. This is equipped with a 500 ma. x-ray table. A monitor selector covers a full range of ma. to 500, and Kv. to 125 under control of impulse timer, which measures from 1/60 to 14 seconds. Safety interlocks to prevent accidental overload on x-ray tubes are provided. Photo-timing is available for a complete range of examinations. The table is motor-driven, with angulation from 45 degrees Trendelenburg to 90 degrees vertical. The motor-driven spot-film device has a 14 x 14 fluoroscopic screen, and takes 8 x 10 cassettes which can be exposed in automatic sequence. Photo-timing is also available for spot films. The ceiling tube-mount permits positioning of x-ray tube anywhere within a space of 328 cubic feet surrounding the table. Thus, radiography is possible on stretcher at front and ends of table, and 60-inch lateral radiography across the table is possible. Magnetically controlled positioning locks and room lighting are incorporated in the ceiling suspension. The floor of the x-ray room is thus left entirely clear of obstruction with this type of tube mount. There is also a horizontal stereo cassette changer for chest and upright radiography. This is complete with automatic reciprocating grid and photo-timing. Directly across the hall is room no. 5, which is equipped in a similar manner to room 4. Adjacent to room 5 is also a dressing room area with cubicles and washrooms.

Returning along the east side of the department, next to room 5, is an automatic film-processing unit that completely processes film from exposed to dry state, ready for reading, at the


SECOND FLOOR
SURGERY DEPARTMENT
CORRIDOR
MAJOR SURGERY
STERILIZING
VIEWING ROOM
INDUCTION ROOM
ORDERLY STORAGE
STORAGE
ORTHOPEDICS
UROLOGY
INSTRUMENTS
WORK ROOM
OPHTHALMOLOGY
NOSE & THROAT
SURGERY
CYSTOSCOPY
EMERGENCY
ANESTHETIST
CHIEF ANESTHETIST
NURSES
DOCTOR'S LOUNGE
SURGEON'S OFFICE
ANESTHETIC RECOVERY ROOM
RECOVERY ROOM
STAFF ELEVATOR LOBBY
PUBLIC ELEVATOR LOBBY
SERVICE ELEVATOR
EXISTING BUILDING
COST ROOM
SURG. STORE
GENERAL OFFICE
PROCTOLOGY OFFICES
WAITING ROOM
STAFF ROOM
TELEPHONE
UTILITY ROOM
DARK ROOM
LIBRARY & CLINIC
X-RAY
VIEWING ROOM
OFFICE
DOCTOR'S OFFICE
RECEPT.
EXAMINATION
COBALT 60 ROOM
SECY.



Therapeutic radiology, showing control station for the Siemens 220-kilowatts.

rate of 60 per hour. All chemicals are automatically replenished and filtered. This is a through-the-wall type of unit, in which the films are loaded in a darkroom, but emerge in a lighted room.

Next to this is radiographic room 6, which contains a 500 ma. x-ray generator, with KX 8 control. An R 33 fluoroscopic and radiographic table is located here. A rotating anode tube is present for fluoroscopy and spot films. In conjunction with this table, there is a motor-driven vertical and horizontal planigraph fitted to the tubestand and table.

Next to this room is a large room equipped with cabinets and 12 separate viewing boxes, together with a mobile viewing box containing eight separate units. This is used as a museum and also as a classroom. There are facilities for a projector and a permanent screen and blackboard also present here.

Adjacent to this room, on the north side, is the barium kitchen and general utility room, with cupboard space provided for special equipment. Next is a manual darkroom, with temperature controlled solutions, and emergency films are processed in this area. To the north of the darkroom is the supervisor's office, together with a small reception area, and immediately north of this is the main waiting room. The last room on the east side of the department is the staff restroom.

In addition to the equipment described, there are two mobile x-ray units, one a 15 ma. unit; the other, a full-wave rectified 100 ma. and 100 kv.p. mobile unit. This unit is also equipped to feed the shockproof tube on the Sweet eye localizer.

Two urological rooms are equipped with Sisk and Hugh Young urological tables, each with rotating, anode x-ray tube and Bucky, and between these rooms is a small darkroom for developing urological films. A 200 ma. V 12 control, with dual output is present to energize the tube in either room, and safety interlocks are installed to prevent overload on the tubes. There is also a separate fluoroscope in the out-patient department, which is used for chest fluoroscopy. A polaroid unit is also available, which is used primarily for hip pinning and which gives a dry positive print in one minute after exposure. This is also used for emergency operating room work in conjunction with the mobile unit. — *C. W. Hall, M.D., Radiol. Cert. (C)*

Department of Radiation Therapy

RADIATION therapy is a relatively young branch of medicine. The therapeutic effects of ionizing radiations were discovered very shortly after the discovery of x-rays and radium; and for many years radio-diagnosis and radio-therapy were practiced in the same department. In the past 30 years radiation physics has expanded enormously as a science and it has formed the basis of modern radiation therapy. It soon became apparent that this field formed a speciality in its own right and, particularly in Great Britain and most of the continent of Europe, diagnostic roentgenology and radiation therapy have become two separate departments. This trend has been followed in Canada and some parts of the United States of America. At St. Boniface Hospital an independent department of radiation therapy was established in February, 1955. This department is operated by the Manitoba Cancer Relief Research Institute and functions for all practical purposes as a department of St. Boniface Hospital. The department of radiation therapy is

One of the 14 operating rooms, showing the viewing room for students.

fortunate in being situated in the new wing. Because of the peculiar problems associated with the protection of non-radiological personnel against the irradiation employed therapeutically, many departments of this nature are situated below ground. However, it has been found possible to construct the department in such a way as to have it situated on the second floor so that all treatment rooms and laboratories can enjoy the full benefit of daylight. The staff of the department consists of trained specialists in radiation therapy, a hospital physicist and nurses who have received special instruction in the techniques of radiation therapy and who have become qualified technicians in this field. A considerable proportion of patients treated here suffer from one form or other of cancer, but, at the same time, a number of patients are treated who are suffering from other diseases.

The Cobalt Beam Unit enables the patient to receive treatment in what is commonly known as the supervoltage range. Its radiation is equivalent to that of an x-ray machine operating at 3 million volts. These highly penetrating radiations enable us to give high doses of radiation to deep seated tumours and they have markedly reduced the general reaction which radiation has caused in patients in the past. The Cobalt Beam therapy unit here has the advantage of being mounted on a movable stand which enables it to be rotated around the patient and thus further to improve the physical conditions under which the patient is being treated. Apart from the Cobalt Beam unit, two units are available for treatment at 220 kilovolts. One of these machines again is so constructed as to rotate around the patient, enabling us to deliver a similar type of treatment to that given on the Cobalt Beam unit. These two machines are being used for patients suffering from tumours less deeply placed or from comparable conditions. Finally, two x-ray machines are available in the superficial x-ray therapy range, one operating at 100 kilovolts and the other one at 60 kilovolts. The latter machine is capable of delivering a very high dose in a very short time and is thus particularly suitable for patients suffering from superficial lesions who cannot or will not retain the same position for any length of time. Such a condition often arises where a birth mark is treated in a young baby.

The hospital physicist's work is an integral part of this department's activities. He helps to plan and select the best type of physical arrangement to be used in the case of any particular patient; and he calculates the dose which is being delivered at the required location. He has at his command a small laboratory in which he can calculate and measure the necessary data.

The staff of the department of radiation therapy, and through it the staff of St. Boniface Hospital, can call upon a quanity of radium held by the Manitoba Cancer Institute for purposes of implanting radium needles into malignant tumours and radium sources for intra cavitary use. Other radioactive sources can be used for a similar purpose. On several occasions implantation of radioactive gold grains has been performed here. These sources are specially prepared at Chalk River and then delivered to St. Boniface Hospital.

St. Boniface Hospital is also at present constructing a laboratory for the handling of radioactive isotopes and when this is completed it will be possible to utilize radioactive isotopes both in the treatment of cancer and other conditions. There will also be facilities for research work and for tracer investigations to be undertaken. These facilities will be available to the whole staff of the hospital. After the completion of these laboratories the radiation therapy department will be in a position to give a complete service by all forms of external radiation, the implantation of radioactive sources directly into malignant tumours, and finally by the internal administration for treatment or investigation of radioactive materials. — *S. Kramer, M.B., D.M.R.T., F.F.R.*

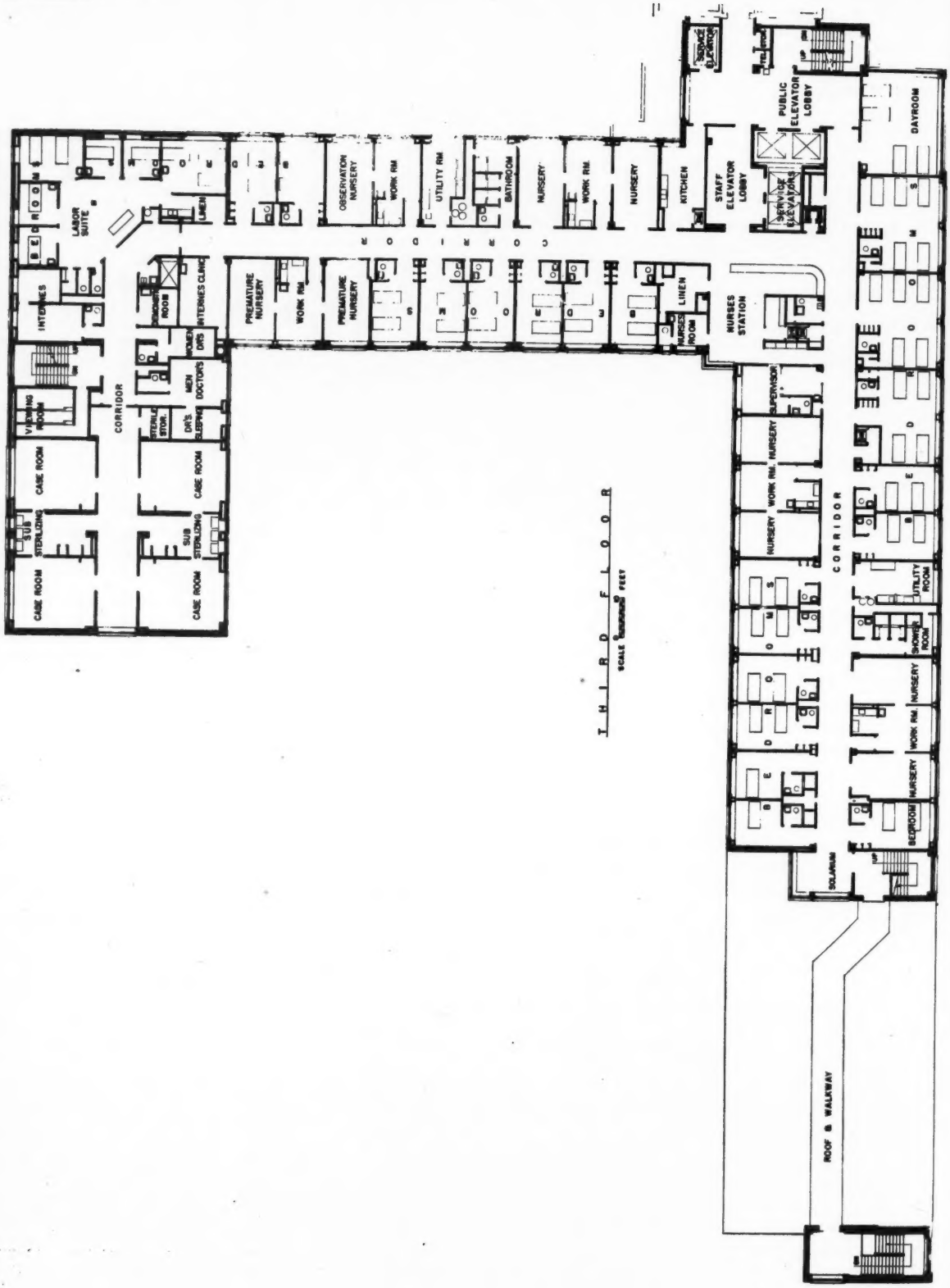
The Post-Anaesthesia recovery room located in the operating suite.

Anaesthesia and Recovery Room

THE new surgical facilities include two areas of patient care which are now recognized as indispensable. These are the post-anaesthesia unit and the post-surgical recovery rooms.

The post-anaesthesia unit is located within the operating suite itself and contains fifteen specially designed stretchers. The latter include many built-in features which will permit rapid variable positioning of the patients, folding intravenous poles, et cetera. Each patient stretcher is located beside a wall panel containing facilities such as regulated suction, blood pressure manometer, and oxygen. Patients are detained in this unit area until they are fully awake, with stable vital signs, and are free of secretions. Their care in this unit is under a group of trained graduate nurses, with the assistance of students. These personnel are in turn directly under the supervision of an anaesthetist, the anaesthesia department office being adjacently located. Provision has been made for basic soundproofing as there are no partitions or curtains between patients' stretchers which might hinder the movement of equipment and personnel. The moving of patients out of the post-anaesthesia unit is expedited through a second large door leading directly to the elevator bank. Space is also provided within the unit for the writing of post-operative orders by the attending doctor as well as for the storage of intravenous solutions, plasma expanders, drugs, et cetera. The unit is linked with the rest of the operating suite and the post-surgical rooms by

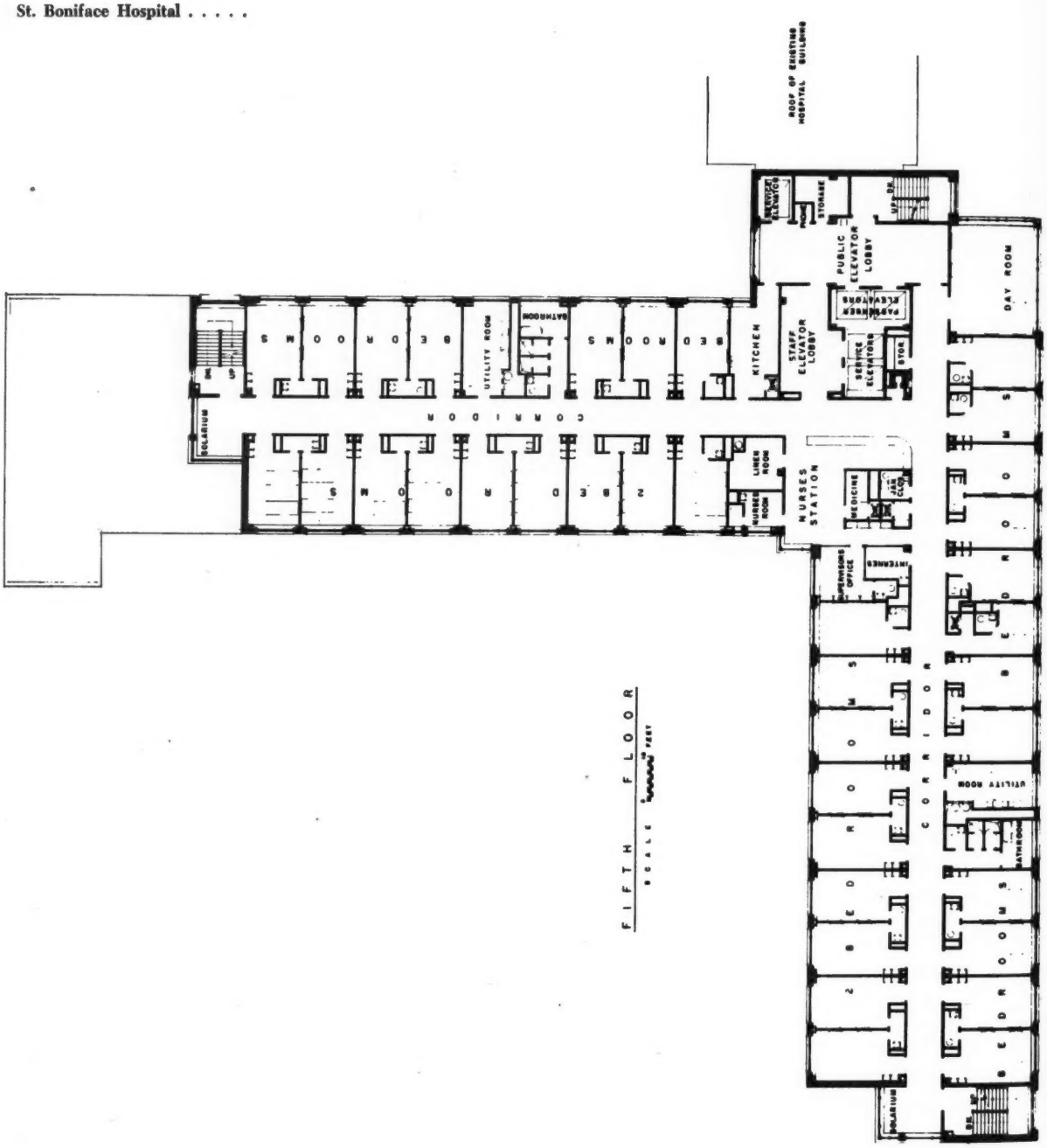
(Continued on page 52)

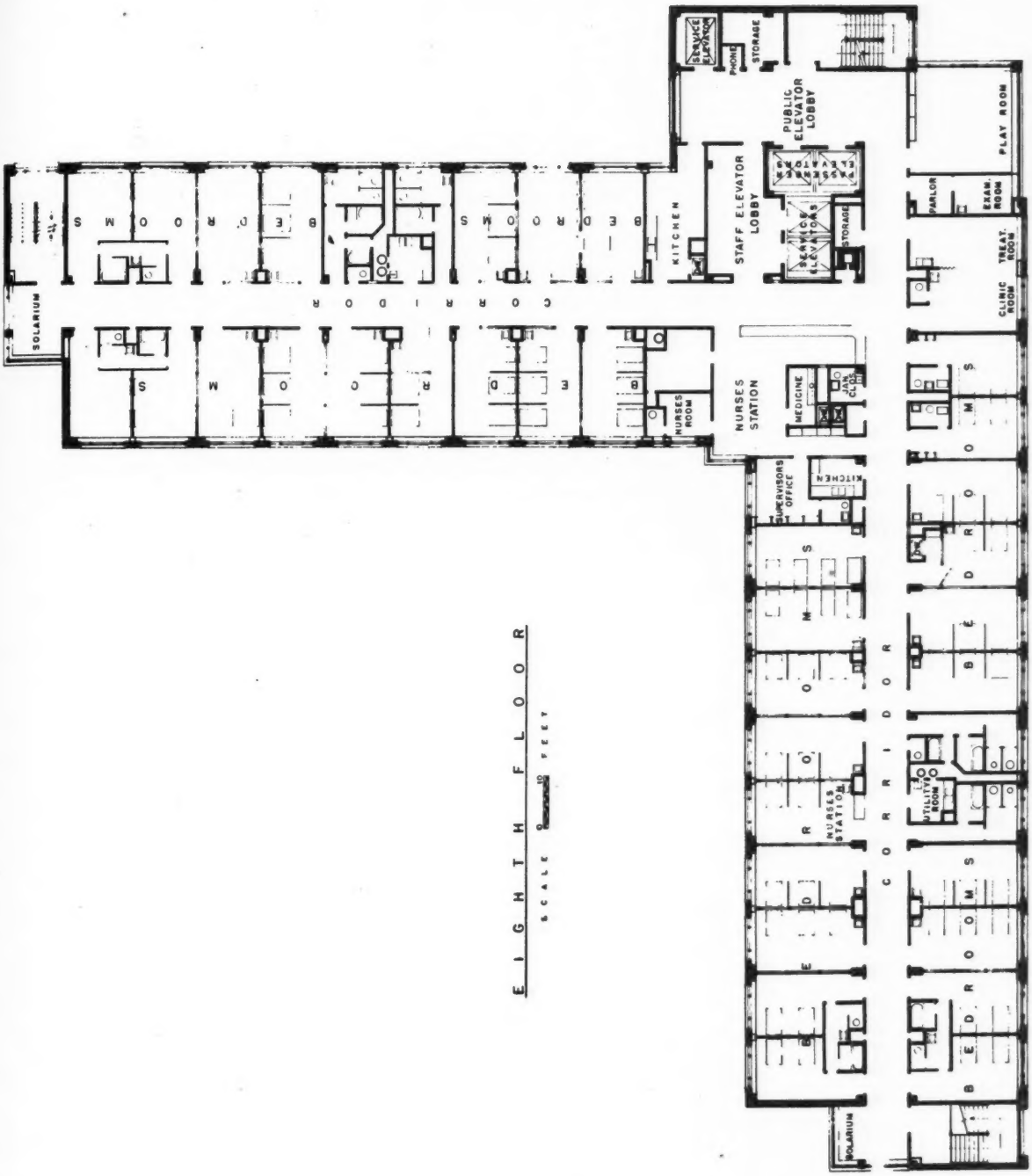

LABOR SUITE
LINEN
OBSERVATION NURSERY
WORK RM.
UTILITY RM.
BATHROOM
NURSERY
WORK RM.
NURSERY
KITCHEN
STAFF ELEVATOR LOBBY
SERVICE ELEVATOR
PUBLIC ELEVATOR LOBBY
DAYROOM
INTERNES
INTERNES CLINIC
PREMATURE NURSERY
WORK RM.
PREMATURE NURSERY
LINEN
NURSES ROOM
NURSES STATION
SUPERVISOR
NURSERY
WORK RM.
NURSERY
CORRIDOR
UTILITY ROOM
SHOWER ROOM
NURSERY
WORK RM.
NURSERY
BEDROOM
SOLARIUM
ROOF & WALKWAY
CORRIDOR
MEN DOCTORS
WOMEN DRS.
DR'S SLEEPING
STERILE STOR.
VIEWING ROOM
CASE ROOM
SUB STERILIZING
CASE ROOM
CASE ROOM
SUB STERILIZING
CASE ROOM
THIRD FLOOR
SCALE FEET

Four-bed ward showing bathroom facilities.

Private room.

St. Boniface Hospital . . . . .





EIGHTH FLOOR

SCALE 10 FEET

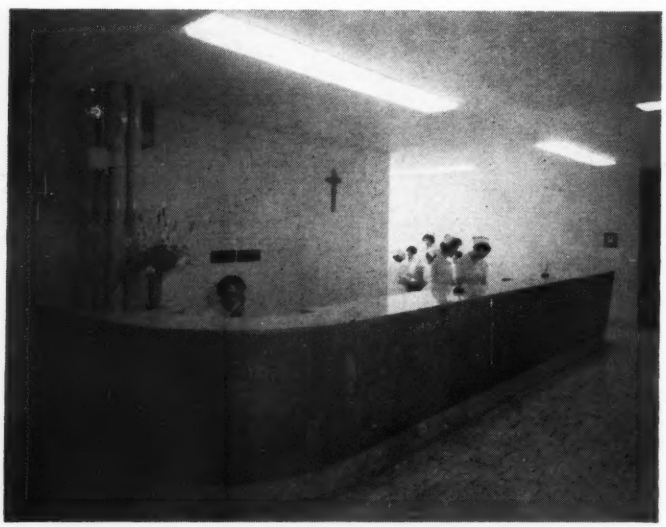
One of five nurseries—nurses' work room located between two groups of eight bassinets.

(Continued from page 47)

the intercom system. Being on the same floor at the x-ray and laboratory facilities, emergency requisitions in the immediate post-operative phase are greatly facilitated. There is universal agreement that the post-anaesthesia room has permitted better patient care during the immediate post-surgical period and eliminated the dangers of transferring patients to the wards while not fully recovered from their anaesthesia.

The post-surgical section is also located on the second floor of the new wing, in close proximity to the operating suite, the laboratory and x-ray facilities. It accommodates sixteen patients and is semi-partitioned into three rooms. This measure is combined with soundproofing in order to minimize noise. Beside each bed there is a recessed panel containing such features as blood pressure apparatus, suction, and oxygen. Each bed is specially constructed for positioning the patient and can be isolated by ceiling curtains in order to permit a limited amount of privacy for the patient. The staff of nurses is specially trained in the post-operative care of major surgical cases, being familiar with the various forms of chest and gastro-intestinal suction, the administration and charting of post-operative fluids and the like. Only patients who have undergone major surgery are directed to this section, at the discretion of their own doctor. They remain in the post-operative room until able to eat and drink and no longer require specialized management. On occasion this unit has accepted other critically ill patients who require almost constant attention, *e.g.*, massive gastrointestinal haemorrhages, or head injuries. Since its inception these features for increased patient care have done much to relieve the shortage of special nurses.

The surgical staff of the hospital have found the care in this post-surgical unit to be generally superior to that provided by special nurses, in that the personnel are unchanging and familiar with the day-to-day management of major post-surgical cases. — *M. Cohen, M.D., L.M.C.C.*



Typical nurses' station such as exists on each floor. Note pneumatic tube.

Paediatrics

THE paediatric department is indeed extensive for a general hospital. The patients coming under the care of this department may be grouped as follows:

1. The general paediatric ward — comprising 88 beds, cribs and incubators and occupying the entire eighth floor of the new wing.

2. The newborn nurseries — consisting of the regular nursery with 46 bassinets, the premature nursery with 12 incubators and bassinets and an isolation nursery with 4 bassinets, this latter being off the general maternity floor and in process of construction.

3. An isolation unit — consisting of 11 beds, cribs and bassinets for the management of infectious diseases.

Each of these is of new construction or has been completely remodelled within the current year. The physical assets are as modern as in any paediatric unit in Canada, either as part of a general hospital or within even such a specialized unit as a children's hospital.

Automatic suction and oxygen supply is piped to each individual unit. The partitions throughout are of glass allowing for observation by the nursing personnel and a wide view for the small patient.

Air conditioning is supplied to all units mentioned above and to all parts of each unit. This is valuable in the management of fever and dehydration particularly in the hot summer months; the patient is infinitely more comfortable and treatment of his condition is made easier. This system also filters out pollens from the air and this has proved to be a most valuable adjunct in the management of asthmatics. It has been a not uncommon experience to bring in a patient and, without any specific treatment, to have the symptoms completely subside afer a few hours in this artificial atmosphere.

An "intercomm" system supplies instant communication between the individual rooms and the nurses' stations. A pneumatic tube system serves these

A two-crib ward in paediatrics.

areas as well as all other departments in the hospital. Conference rooms with blackboard and other teaching facilities are an important part of each ward.

The newborn nurseries are divided into individual units of 16 bassinets and these are disposed in proximity to the mothers. They are roomy, well lighted nurseries, each divided into two halves with a central work-room where supplies are kept and where the doctor can examine the baby; each half is separated from the work-room by a glass partition and no one but the nurse or nurses' aid enters the nursery proper. In the premature nursery a somewhat different situation applies — with the doctor entering the nursery after thoroughly scrubbing his hands and donning a mask and gown. Wide glass partitions separate each half of the individual nurseries from the hallway outside and the mother can at any time, wander across and observe her baby where he or she is in plain view.

The general paediatric ward, situated as it is high up on the eighth floor, is admirably suited to a modern type of paediatric care. Wide ultra-modern thermopane windows provide a view across the city to the quiet countryside beyond. — *A. DePape, M.D., F.R.C.P. (C)* ●

Emergency Hospital Services

Evelyn A. Pepper, R.N.,
Nursing Consultant,
Civil Defence Health Services,
Department of
National Health and Welfare,
Ottawa.

THE responsibility for civil defence was vested in the Department of National Health and Welfare in 1951. At that time Civil Defence Health Services planners held the firm conviction that if plans were developed for a major disaster and if these plans were flexible, then the organization would be able to cope with disasters of lesser magnitude, such as natural disasters, in which smaller numbers of people are involved, as compared to the numbers affected by a large scale disaster, such as war. This thinking added stimulus to individual planners but did not produce the desired response from large numbers of people required to implement the plans.

With the development of hospital disaster plans, a program which has been sponsored federally for the past two years, a new interest was sensed. Planners were more interested in dealing with the moderate extension of a known situation. Co-workers and interested citizens alike were much more interested in planning for situations definitely within the realm of their personal interest and imagination. Therefore, for the past two years, Civil Defence Health Services planners, still contending, of course, that the plans must be flexible and practical, have correctly placed the emphasis on preparedness to meet peacetime disasters. The small groups thus formed to meet small disasters would be the natural leaders around whom larger groups would rally in the event of a major disaster.

Someone has described civil defence as a way of living through a disaster, not dying in one — as a way of helping others in a disaster, not requiring help from others. This would seem a fairly adequate definition for the average Canadian. But the broad concept of civil defence planning requires a fuller understanding through public education. It would seem of vital importance, in fact, that a proper understanding of the Canadian civil defence program should become a criterion for good citizenship in our country today. It would seem of vital importance that civil defence planning become the subject of study by each and every Canadian, if we are to fulfil our obligations as citizens of this great land.

You may or may not be aware that many professional groups are already incorporating civil defence information and direction into the basic curricula of their university courses. The Canadian Civil Defence College at Arnprior, Ont., is being used as the centre of instruction to teach those who teach others. It is anticipated, for instance, that by next Fall, all the faculties of medicine and pharmacy will be instructing and directing their students regarding their particular responsibility in the civil defence program. In seven of our provinces, the university and hospital schools of nursing are including disaster nursing in their basic curricula.

It is hoped that with the beginning of a new teaching year all approved schools of nursing across Canada will do likewise. This is but a quick review of what is being done in the medical and paramedical fields. Much remains to be done in and through basic education to promote civil defence thinking, interest and action.

As hospital administrators, directors of nursing, or hospital auxiliary per-

sonnel, you should be prepared to assume your proper role in the program of emergency hospital services for civil defence. Therefore, you ask, "What are the plans?"

Divisions

A brief summary of civil defence casualty services arrangements shows that these plans are divided into two parts, namely: primary treatment services and hospital services.

Primary treatment services consist of personnel, transportation, equipment and supplies for:

(a) Casualty collecting units which provide first aid to the injured at the site of rescue and early evacuation of the casualties to:

(b) Advanced treatment centres set up as close to the disaster site as possible in order to function safely. Here the injured would receive first medical treatment and first nursing care. In a peacetime disaster, this unit could be set up quickly, close to a disaster site to act as a screening centre. In this way, persons with minor injuries could be treated without burdening the nearby hospitals to which the more serious cases would naturally be directed.

Hospital Services include: (a) existing hospitals with functions altered to provide medical care under disaster conditions; (b) improvised hospitals established in suitable buildings, such as schools.

Evacuation

The advent of larger atomic weapons made it necessary for all concerned with civil defence planning to take another look at the results caused by these new mass destructor weapons. And what was seen? Briefly it was this. Larger areas of total destruction were observed as well as wide-spread radio-active contamination. The greatest damage was caused by blast and accompanying fires, but radioactive dust enveloping hundreds or thousands of square miles down-wind contaminated the small hamlets, villages, and towns lying in the wake of the wind.

As a result of these observations made following the detonation of large atomic weapons, evacuation or withdrawal of population from strategic areas has become an accepted principle. Such evacuation would take place on the following phased basis:

Phase "A". Pre-attack evacuation of pre-selected large cities, *e.g.*, the thinning out of populations by evacuating priority groups. This phase would be enacted once a state of emergency had been declared.

Phase "B". Planned withdrawal from pre-selected cities. This phase would be put into operation on the alert signal. The populace remaining after Phase "A" evacuation would move out.

Phase "C". The counter-action or relief action which is put into operation in any area where an attack has taken place.

Phase "D". Assistance and rehabilitation provided in both disaster areas and reception areas.

It has been determined that priority for evacuation would be given to certain groups and types of people. These include: (a) young children accompanied by their mothers or teachers; (b) expectant mothers; (c) the aged, and the handicapped; (d) the chronically ill and the sick, in hospitals or in their homes. These groups would be evacuated in the phase "A" period.

Since doctors, nurses, and pharmacists are key personnel in a disaster crisis, a percentage of them would accompany the phase "A" evacuee group. There are two specific reasons for this decision:

(1) To ensure an adequate force of trained personnel to give medical aid to casualties through the setting up of Advanced Treatment Centres on the periphery of the disaster area; and to maintain a supply distribution through assembly points.

(2) To establish and maintain emergency health services in communities suddenly over-populated with evacuees.

It has been estimated that approximately one-fifth of the total population of Canada live in strategic areas. Of this total more than 40 per cent are included in what we term "the priority groups". If an evacuation of priority groups takes place from strategic areas, approximately one and one-half million persons would have to be absorbed in smaller communities. It is inevitable, therefore, that such mass movement of population would tax profoundly the normal health facilities and personnel of any receiving community. These statistics strengthen the need to safeguard our medical and paramedical personnel through preplanned evacuation in order that they will be available in adequate numbers to serve where they are needed most, following a major incident.

Two Types of Hospital

You will recall that in our casualty services evacuation plans we relied on two types of hospital. First, the existing hospital, for which there are these two types of planning:

(1) Where staff and facilities are intact, the hospital's disaster plan should go into effect. This plan, as all must know, has been described and recommended through our hospital disaster institutes. Some 200 Canadian hospitals have been represented at these institutes and the majority have developed their own plans since then.

(2) where staff, patients and possibly some of the valuable portable hospital equipment are intact and relocated. This, of course, is a situation controlled by pre-attack evacuation. To date, in Canada, we have not activated this type of planning but we hope to test such an evacuation through the assistance of one of our major hospitals.

Second, the improvised hospital, when you have neither staff nor facilities, but have many persons requiring immediate surgical and medical care.

In the beginning it was emphasized that our plans must be flexible and this is indeed true, especially in relation to the functions of the improvised hospital, which are:

(1) to act as a support unit set up on the periphery of a disaster area, to provide medical treatment to casualties.

(2) to serve as a small community hospital caring for ill evacuees and providing health service to the community as a whole.

(3) to act as a supplementary unit to an over-taxed community hospital.

(4) to be a work centre to which a hospital from a key area could be evacuated.

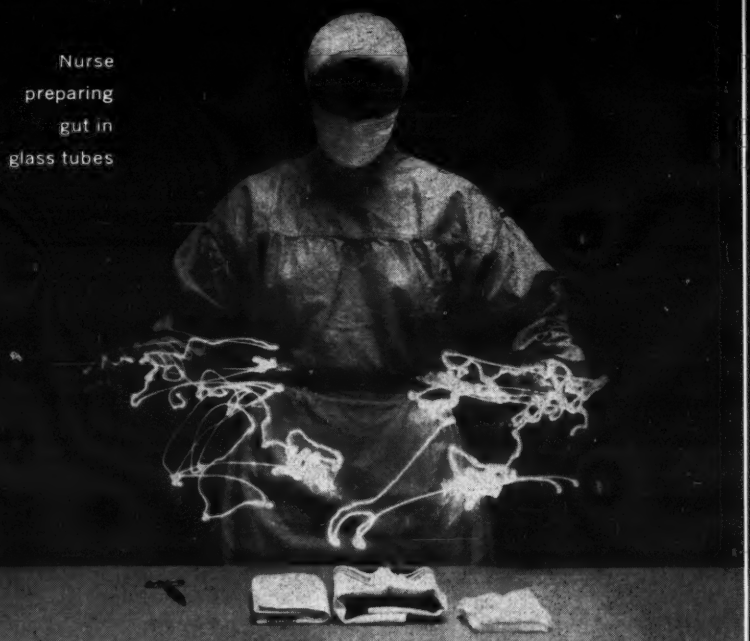
As civil defence plans progress, a great reliance for survival is being placed on the moderate-sized town and smaller communities with or without hospital facilities. The improvised hospital is one of the means taken by Civil Defence Health Services to assist these communities to maintain adequate health services. Such units would either supplement existing hospital facilities, or become the focal point of health services where such facilities were previously non-existent but, due to an influx of evacuees, were now urgently required. These units, capable of accommodating 200 patients at any one time, would become static. They would be operated by local professional personnel reinforced by trained personnel drawn from the evacuee group. In the event that such units were further taxed by the reception of casualties from the disaster area, mobile support teams would augment the existing staff.

Hospitals evacuated intact from key areas would, of course, be prepared to man their new improvised location.

Improvised Hospital Unit

The improvised hospital unit will consist of nearly 350 different items ranging from safety pins to a 2,500-gallon nylon rubber watertank. A complete x-ray unit, capable of producing a positive plate in less than one minute,

(Continued on page 128)



Nurse preparing gut in glass tubes

Nurse preparing **D & G SURGILAR** Sterile Pack of surgical gut

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GET BROKEN GLASS OUT OF THE O. R.

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photo technic: *light-tracings of hands to which bulbs are attached.*

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SURGICAL PRODUCTS DIVISION
MONTREAL, CANADA

From left to right: Sister Clarissa, Sydney, N.S.; Sister Kerr, Vallée Lourdes, N.B.; His Excellency, the Most Rev. N. Robichaud, Moncton, N.B.; Rev. Henri Légaré, Ottawa, Ont.

Maritime Conference Meets in Moncton

THE 32nd annual meeting of the maritime conference of the Catholic Hospital Association was held this year at the Notre-Dame Academy in Moncton, August 28 and 29. Prior to the general sessions a meeting of the executive board was held on the evening of August 27.

The official opening was on Tuesday morning with the celebration of mass in the Academy chapel by his Excellency, Most Rev. Norbert Robichaud, Archbishop of Moncton. A special sermon was delivered by Rev. Joseph B. Nearing, pastor of Sydney Mines, N.S., and spiritual director of the conference. Father Nearing took as his text the parable of the Good Samaritan, applying this to hospital personnel.

At the opening session of the general meeting good wishes were extended by Archbishop Robichaud, followed by greetings from the city of Moncton extended by Alderman William Creaghan, in the absence of Mayor H. A. Joyce. A message from the Catholic Hospital Association of Canada was delivered by the executive director, Rev. Henri Légaré. Following the address by the president of the conference, Sister Kerr, an address entitled "Recent Trends in National Health Insurance" was given by Father Légaré. Rev. J. B. Nearing presided during the afternoon session on Tuesday when a panel of clergymen discussed the report of the survey on "Certain Aspects of Christian Orientation in Our Catholic Hospitals". This survey had been done by Rev. E. Chiasson, Sydney, N.S. Those taking part in the panel discussion were: Rt. Rev. F. M. Daigle, Moncton, N.B.; Rt. Rev. T. LeBlanc, Pubnico, N.S. Rev. A. McLeod, Antigonish, N.S.; Rev. R. Phelan, Charlottetown, P.E.I.; Rev. E. Godin, Bathurst; Rev. E. Chiasson, Campbellton, N.B.

The report of the delegates of the Conference to the 1956 Convention of the Catholic Hospital Association held in Milwaukee from May 21 to 24 was given by Sister Kerr.

On Wednesday morning Sister M. Clarissa, first vice-president, presided. Mother Bujold gave a comprehensive report on her survey in nursing education and the reports of the secretary-treasurer were given by Mother Albert. Following the reports, Mrs. A. Carbonneau, management consultant, Training Personnel, Montreal, spoke on "How to Obtain Diligent Work Performance". A discussion period followed this address.

At the final session Sister Kerr presided. Reports were given by the standing committees. Father Nearing presented a tentative constitution and by-law for the conference. Sister Thérésa Carmel reported for the publicity committee, and Sister Clarissa for the ways and means committee. Roland Bisson, president of the Robi Company, Montreal, gave an instructive discourse on "Good Housekeeping" and presented a film on "Cleaning and Maintenance of Floors". A discussion period followed.

A report of the resolutions committee was given by Sister Mary of Calvary, Antigonish, N.S. The meeting closed with the singing of "Ave Maris Stella".

The officers will be the same as in 1955:

President: Sister Kerr, Sanatorium Notre-Dame de Lourdes, Vallée Lourdes, N.B.

First vice-president: Sister M. Clarissa, St. Rita Hospital, Sydney, N.S.

Second vice-president: Sister M. Magdalen, St. Clare's Mercy Hospital, St. John's, Nfld.

Secretary-treasurer: Mother Albert, Provincial House, Vallée Lourdes, N.B.

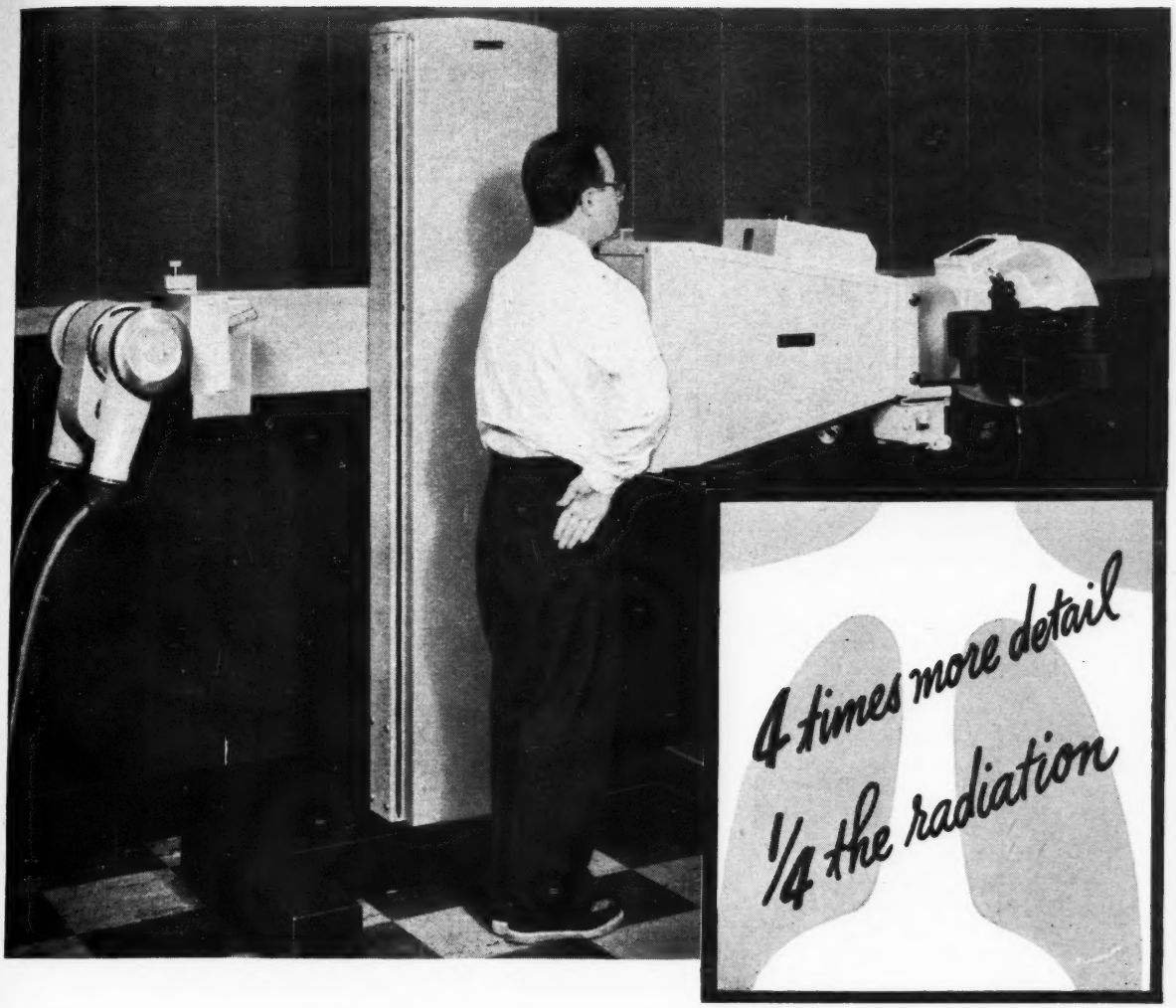
Spiritual director: Rev. J. B. Nearing, Sydney Mines, N.S.

Executive Committee: Sister St. Hugh, Charlottetown, P.E.I.; Mother M. Bujold, Provincial House, Vallée Lourdes, N.B.; Sister Thérésa Carmel, St. Joseph's Hospital, Saint John, N.B.

Executive Board: Sister Catherine Gerard, Halifax Infirmary, Halifax, N.S.; Sister Paul of the Cross, St. Martha's Hospital, Antigonish, N.S.; Sister Jean Eudes, St. Elizabeth's Hospital, North Sydney, N.S.; Sister Kenny, Hôtel-Dieu, Chatham, N.B.—*Submitted by Sister Thérésa Carmel, publicity chairman.*

Take a Walk

Autumn is the ideal time for walking, that most economical and efficient form of exercise. Since it requires no equipment other than comfortable and suitable shoes, it should be a regular part of the daily program, even for the aged person, if he is able to get around normally.



New G-E PHOTOROENTGEN unit
provides better films faster

In chest survey programs, earlier discovery of pathology is possible with this new General Electric duplex photoroentgen unit with its Fairchild-Odelca super-speed camera. You get three important advantages: films produced with this advanced mirror-optics system reveal much greater detail — *300% better resolution.* Patient-motion problems, major cause of blurring, are sharply curtailed — *exposures are cut 75% to 80%.* As a result, patients receive *75% less radiation per exposure.*

General Electric's *complete line* of photoroentgen apparatus includes super-speed mirror-optics cameras in both single and duplex models . . . in-line and angle-hood camera designs . . . units with conventional lens systems . . . roll-film or cut-film operation. Film sizes offered: 70mm, 4 x 10, 4 x 5, and 4 x 4. Actually this range of equipment is so broad you are assured of a unit ideally suited to your individual requirements — whatever your patient load . . . whatever your preference.

Your local G-E x-ray representative can provide full details . . . help you evaluate these units in relation to work loads . . . assure the most practical investment. And be sure to ask him about renting — your alternate way to obtain the finest x-ray apparatus *without initial capital investment* through the G-E MAXISERVICE® rental plan. Or write the nearest office of General Electric X-Ray Corp., Ltd. — Montreal, Toronto, Vancouver, Winnipeg.

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Certain facts regarding

Hospital Administrators in Canada

W. Douglas Piercey, M.D.

WE ARE asked occasionally what is the proportion of men and women administering Canadian hospitals and what is the most common title used to describe the chief executive officer. To answer these questions a study was undertaken, based on the 1956 *Canadian Hospital Directory* and questionnaires submitted by the hospitals for that publication. The survey includes all hospitals classified as public general, public special, and most of those owned by the federal and provincial governments. Excluded from the federal group are Department of National Defence hospitals and Department of National Health and Welfare immigration stations. Some 251 private hospitals were excluded also.

A total of 1,042 hospitals of all sizes were surveyed: 655 (63 per cent) are administered by women and 387 (37

(Continued on page 62)

Table 1
Hospital Administrators

	Canada	B.C.	Alta.	Sask.	Man.	Ont.	Que.	N.B.	N.S.	P.E.I.	Nfld.	Y.T. N.W.T.
Women	655	32	93	120	70	141	98	27	38	3	17	16
Men	387	76	26	45	24	98	47	18	15	6	27	5
Total	1042	108	119	165	94	239	145	45	53	9	44	21

Table 2
Hospital Administrators in Hospitals Owned By Religious Groups

	Canada	B.C.	Alta.	Sask.	Man.	Ont.	Que.	N.B.	N.S.	P.E.I.	Nfld.	Y.T. N.W.T.
Women	259	17	35	20	15	48	88	15	10	2	2	7
Men	28	6	3	2	3	0	8	1	1	0	0	4
Total	287	23	38	22	18	48	96	16	11	2	2	11

Figure I

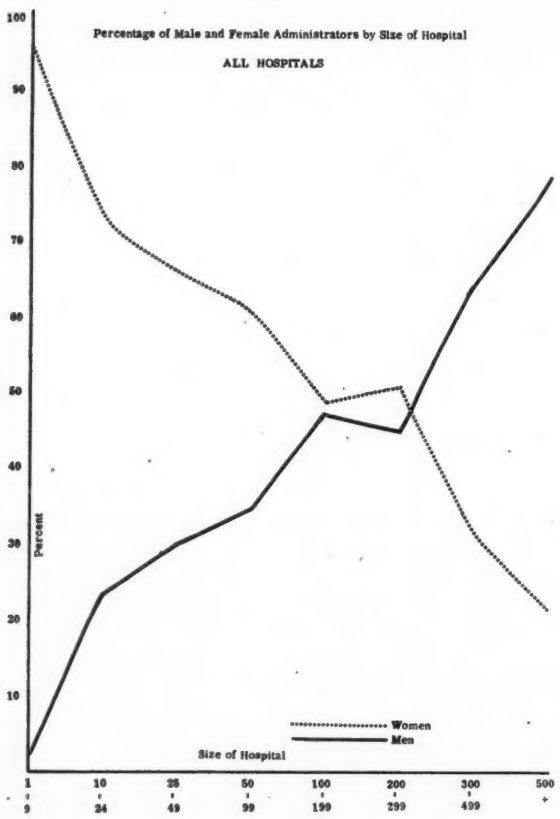
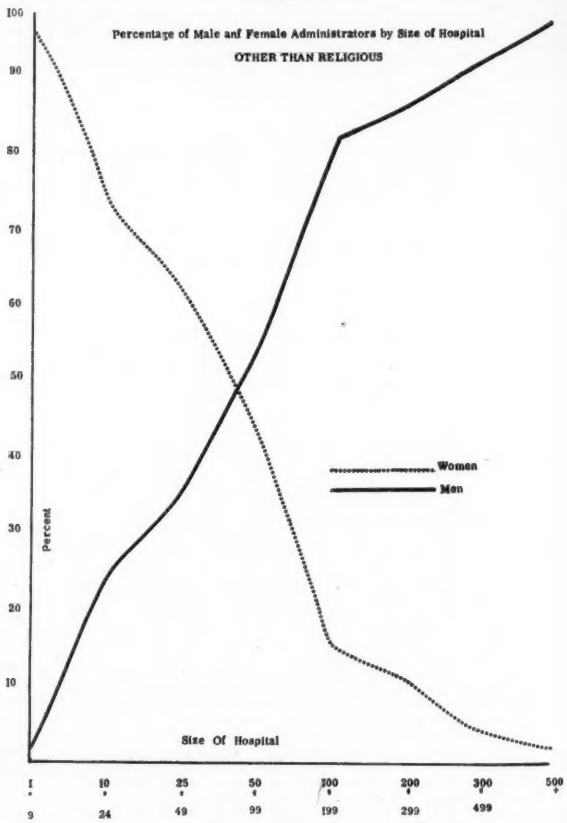


Figure II



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(Continued from page 58)

per cent) by men. The highest proportion of women to men is found in the province of Alberta (78 per cent) and the lowest in British Columbia (30 per cent). For details of distribution by provinces see Table 1. Two hundred and eighty-seven hospitals owned by religious groups have 259 women as chief executive officers and 28 men (Table 2). Of the remaining 755 hospitals, 396 are administered by women and 359 by men (Table 3).

Both women and men are found as chief executive officers of Canadian hospitals of all sizes. In this survey the size classification given in the Tables of the *Canadian Hospital Directory* was followed. This divides hospitals into eight groups: 1-9 beds; 10-24; 25-49; 50-99; 100-199; 200-299; 300-499; and 500 beds and over. The highest percentage of women is found in hospitals under 100 beds and the highest percentage of men in hospitals of 100 beds and over. Seventy-seven per cent of the women are employed in hospitals under 100 beds, while 55 per cent of the men are in charge of hospitals over 100 beds (Table 4). From Figure I it will be seen that the percentage of men to women in hospitals of the various categories are most nearly equal in the 100 and 200 size group. When hos-

(Concluded on page 120)

Table 3

Hospital Administrators in Hospitals Owned By Other Than Religious Groups

	Canada	B.C.	Alta.	Sask.	Man.	Ont.	Que.	N.B.	N.S.	P.E.I.	Nfld.	Y.T. N.W.T.
Women	396	15	58	100	55	93	10	12	28	1	15	9
Men	359	70	23	43	21	98	39	17	14	6	27	1
Total	755	85	81	143	76	191	49	29	42	7	42	10

Table 4

Hospital Administrators By Size Of Institution

Bed Size		1-9	10-24	25-49	50-99	100-199	200-299	300-499	500+
Canada	—Women	99	171	138	94	82	32	21	18
	—Men	3	56	64	53	79	29	43	60
	Total	102	227	202	147	161	61	64	78
B.C.	—W	9	4	8	6	2	0	2	1
	—M	0	12	21	12	15	5	6	5
Alta.	—W	4	25	32	21	6	1	4	0
	—M	0	8	3	2	3	1	3	6
Sask.	—W	22	69	19	5	2	2	1	0
	—M	1	11	11	8	5	2	2	5
Man.	—W	17	27	14	6	2	2	1	1
	—M	0	3	7	3	3	2	0	6
Ont.	—W	18	15	38	28	26	7	4	5
	—M	0	4	8	13	25	10	14	24
P.Q.	—W	1	6	7	18	30	16	9	11
	—M	0	1	6	5	13	3	8	11
N.B.	—W	2	9	6	2	7	1	0	0
	—M	1	2	1	3	4	3	3	1
N.S.	—W	4	11	10	6	4	3	0	0
	—M	0	0	2	2	5	2	3	1
P.E.I.	—W	1	0	1	0	1	0	0	0
	—M	0	1	1	0	2	0	2	0
Nfld.	—W	12	3	0	0	2	0	0	0
	—M	1	14	3	2	3	1	2	1
Y.T., N.W.T.	—W	9	2	3	2	0	0	0	0
	—M	0	0	1	3	1	0	0	0

Table 5

Terms Used to Designate the Chief Executive Officer

	Canada	B.C.	Alta.	Sask.	Man.	Ont.	Que.	N.B.	N.S.	P.E.I.	Nfld.	Y.T. N.W.T.
Superintendent	275	6	25	25	31	129	7	10	32	2	6	2
Administrator	215	54	21	14	14	56	26	12	11	4	2	1
Matron	159	3	45	76	26	1	1	4	..	..	..	3
Superior	98	6	5	5	..	3	74	4	..	..	..	1
Nurse in Charge	81	8	6	8	8	25	..	2	..	..	14	10
Medical Superintendent	81	14	9	5	12	17	7	5	6	1	1	4
Medical Officer	25	1	..	..	..	..	1	3	..	..	20	..
Secretary-Treasurer	17	3	2	10	..	..	..	..	..	2	..	..
Secretary Manager	16	1	2	12	1	..	..	..	..	..	..	..
Director	11	3	..	1	..	2	4	1	..	..	..	..
Executive Director	10	..	..	1	..	..	8	1	..	..	..	..
Medical Director	10	2	..	..	..	2	5	..	..	..	1	..
Supervisor	7	..	..	3	2	..	1	..	1	..	..	..
Superintendent of Nurses	4	1	..	3	..	..	..	..	..	..	..	..
Director General	3	..	..	..	..	..	3	..	..	..	..	..
Medical Administrator	3	..	..	1	..	1	..	1	..	..	..	..
General Superintendent	3	..	..	..	..	2	1	..	..	..	..	..
Secretary	3	3	..	..	..	..	..	..	..	..	..	..
Superior and Administrator	3	..	1	..	..	..	2	..	..	..	..	..
Manager	2	..	1	1	..	..	..	..	..	..	..	..
Nurse Superintendent	2	..	2	..	..	..	..	..	..	..	..	..
President	2	..	..	..	..	..	1	1	..	..	..	..
Business Manager	2	..	..	..	..	..	..	1	1	..	..	..
Business Administrator	2	..	..	..	..	1	..	..	1	..	..	..
Director of Nursing	1	..	..	..	..	..	..	..	1	..	..	..
Director and Administrator	1	..	..	..	..	..	1	..	..	..	..	..
General Administrator	1	..	..	..	..	..	1	..	..	..	..	..
Matron-Secretary	1	1	..	..	..	..	..	..	..	..	..	..
Office Manager	1	1	..	..	..	..	..	..	..	..	..	..
Chief Executive	1	1	..	..	..	..	..	..	..	..	..	..
Superior and Superintendent	1	..	..	..	..	..	1	..	..	..	..	..
Superior General	1	..	..	..	..	..	1	..	..	..	..	..
Total	1042	108	119	165	94	239	145	45	53	9	44	21

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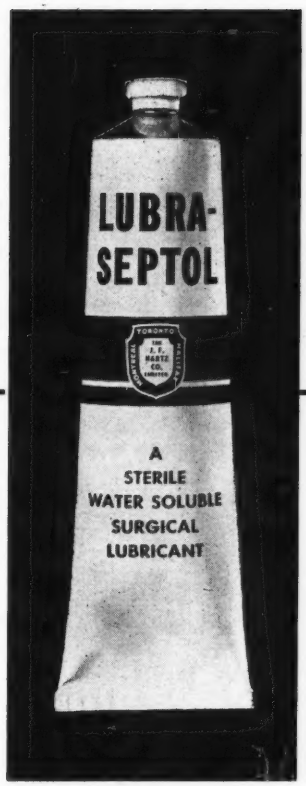

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Certain facts regarding

Hospital Administrators in Canada

W. Douglas Piercey, M.D.

WE ARE asked occasionally what is the proportion of men and women administering Canadian hospitals and what is the most common title used to describe the chief executive officer. To answer these questions a study was undertaken, based on the 1956 *Canadian Hospital Directory* and questionnaires submitted by the hospitals for that publication. The survey includes all hospitals classified as public general, public special, and most of those owned by the federal and provincial governments. Excluded from the federal group are Department of National Defence hospitals and Department of National Health and Welfare immigration stations. Some 251 private hospitals were excluded also.

A total of 1,042 hospitals of all sizes were surveyed: 655 (63 per cent) are administered by women and 387 (37

(Continued on page 62)

Table 1
Hospital Administrators

	Canada	B.C.	Alta.	Sask.	Man.	Ont.	Que.	N.B.	N.S.	P.E.I.	Nfld.	Y.T. N.W.T.
Women	655	32	93	120	70	141	98	27	38	3	17	16
Men	387	76	26	45	24	98	47	18	15	6	27	5
Total	1042	108	119	165	94	239	145	45	53	9	44	21

Table 2
Hospital Administrators in Hospitals Owned By Religious Groups

	Canada	B.C.	Alta.	Sask.	Man.	Ont.	Que.	N.B.	N.S.	P.E.I.	Nfld.	Y.T. N.W.T.
Women	259	17	35	20	15	48	88	15	10	2	2	7
Men	28	6	3	2	3	0	8	1	1	0	0	4
Total	287	23	38	22	18	48	96	16	11	2	2	11

Figure I

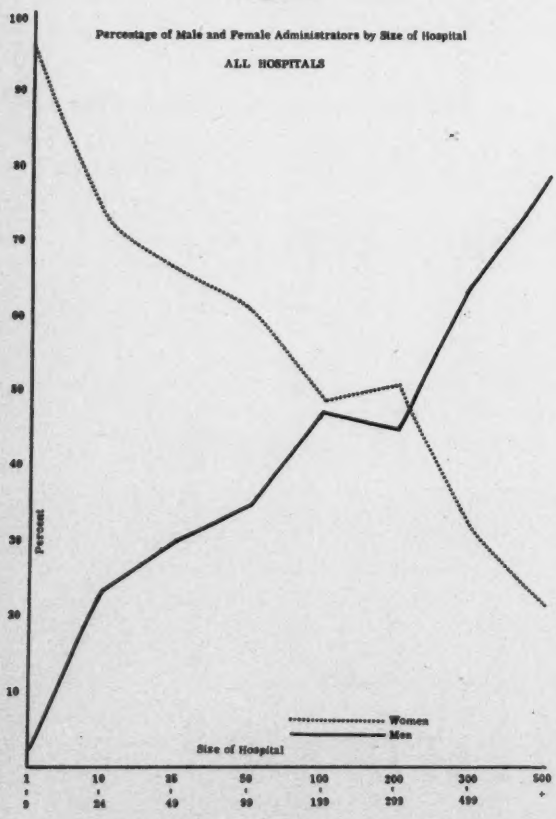
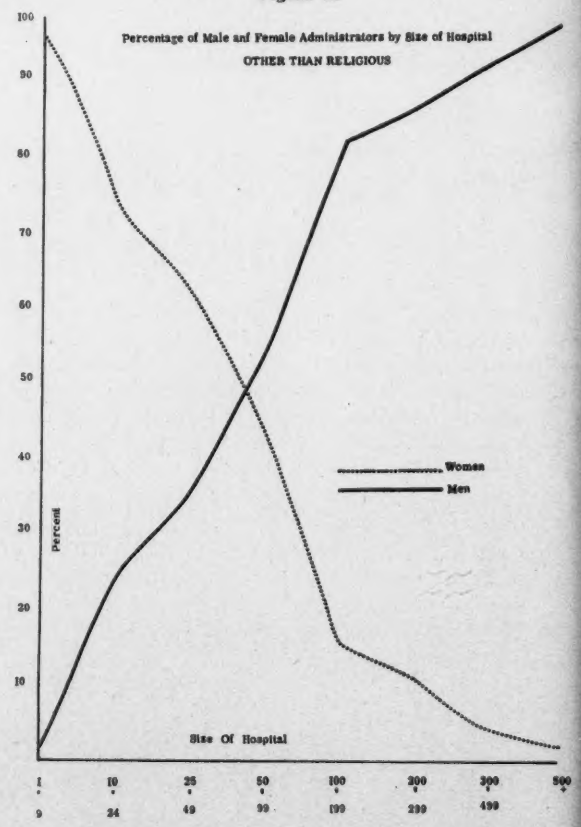


Figure II



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VANCOUVER REGINA WINNIPEG EDMONTON SASKATOON CALGARY

(Continued from page 58)

per cent) by men. The highest proportion of women to men is found in the province of Alberta (78 per cent) and the lowest in British Columbia (30 per cent). For details of distribution by provinces see Table 1. Two hundred and eighty-seven hospitals owned by religious groups have 259 women as chief executive officers and 28 men (Table 2). Of the remaining 755 hospitals, 396 are administered by women and 359 by men (Table 3).

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(Concluded on page 120)

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Men	359	70	23	43	21	98	39	17	14	6	27	1
Total	755	85	81	143	76	191	49	29	42	7	42	10

Table 4

Hospital Administrators By Size Of Institution

Bed Size		1-9	10-24	25-49	50-99	100-199	200-299	300-499	500+
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	—Men	3	56	64	53	79	29	43	60
	Total	102	227	202	147	161	61	64	78
B.C.	—W	9	4	8	6	2	0	2	1
	—M	0	12	21	12	15	5	6	5
Alta.	—W	4	25	32	21	6	1	4	0
	—M	0	8	3	2	3	1	3	6
Sask.	—W	22	69	19	5	2	2	1	0
	—M	1	11	11	8	5	2	2	5
Man.	—W	17	27	14	6	2	2	1	1
	—M	0	3	7	3	3	2	0	6
Ont.	—W	18	15	38	28	26	7	4	5
	—M	0	4	8	13	25	10	14	24
P.Q.	—W	1	6	7	18	30	16	9	11
	—M	0	1	6	5	13	3	8	11
N.B.	—W	2	9	6	2	7	1	0	0
	—M	1	2	1	3	4	3	3	1
N.S.	—W	4	11	10	6	4	3	0	0
	—M	0	0	2	2	5	2	3	1
P.E.I.	—W	1	0	1	0	1	0	0	0
	—M	0	1	1	0	2	0	2	0
Nfld.	—W	12	3	0	0	2	0	0	0
	—M	1	14	3	2	3	1	2	1
Y.T., N.W.T.	—W	9	2	3	2	0	0	0	0
	—M	0	0	1	3	1	0	0	0

Table 5

Terms Used to Designate the Chief Executive Officer

	Canada	B.C.	Alta.	Sask.	Man.	Ont.	Que.	N.B.	N.S.	P.E.I.	Nfld.	Y.T. N.W.T.
Superintendent	275	6	25	25	31	129	7	10	32	2	6	2
Administrator	215	54	21	14	14	56	26	12	11	4	2	1
Matron	159	3	45	76	26	1	1	4	..	..	..	3
Superior	98	6	5	5	..	3	74	4	..	..	..	1
Nurse in Charge	81	8	6	8	8	25	..	2	..	..	14	10
Medical Superintendent	81	14	9	5	12	17	7	5	6	1	1	4
Medical Officer	25	1	..	..	..	..	1	3	..	..	20	..
Secretary-Treasurer	17	3	2	10	..	..	..	..	..	2	..	..
Secretary Manager	16	1	2	12	1	..	..	..	..	..	..	..
Director	11	3	..	1	..	2	4	1	..	..	..	..
Executive Director	10	..	..	1	..	..	8	1	..	..	..	..
Medical Director	10	2	..	..	..	2	5	..	..	..	1	..
Supervisor	7	..	..	3	2	..	1	..	1	..	..	..
Superintendent of Nurses	4	1	..	3	..	..	..	..	..	..	..	..
Director General	3	..	..	..	..	..	3	..	..	..	..	..
Medical Administrator	3	..	..	1	..	1	..	1	..	..	..	..
General Superintendent	3	..	..	..	..	2	1	..	..	..	..	..
Secretary	3	3	..	..	..	..	..	..	..	..	..	..
Superior and Administrator	3	..	1	..	..	..	2	..	..	..	..	..
Manager	2	..	1	1	..	..	..	..	..	..	..	..
Nurse Superintendent	2	..	2	..	..	..	..	..	..	..	..	..
President	2	..	..	..	..	..	1	1	..	..	..	..
Business Manager	2	..	..	..	..	..	..	1	1	..	..	..
Business Administrator	2	..	..	..	..	1	..	..	1	..	..	..
Director of Nursing	1	..	..	..	..	..	..	..	1	..	..	..
Director and Administrator	1	..	..	..	..	..	1	..	..	..	..	..
General Administrator	1	..	..	..	..	..	1	..	..	..	..	..
Matron-Secretary	1	1	..	..	..	..	..	..	..	..	..	..
Office Manager	1	1	..	..	..	..	..	..	..	..	..	..
Chief Executive	1	1	..	..	..	..	..	..	..	..	..	..
Superior and Superintendent	1	..	..	..	..	..	1	..	..	..	..	..
Superior General	1	..	..	..	..	..	1	..	..	..	..	..
Total	1042	108	119	165	94	239	145	45	53	9	44	21

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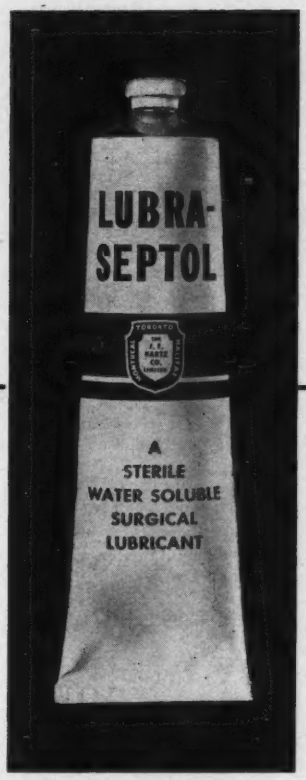

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The Nursing Team Carries On

Sister Mary Melanie,
Superior,
St. Mary's Hospital,
Montreal, P.Q.

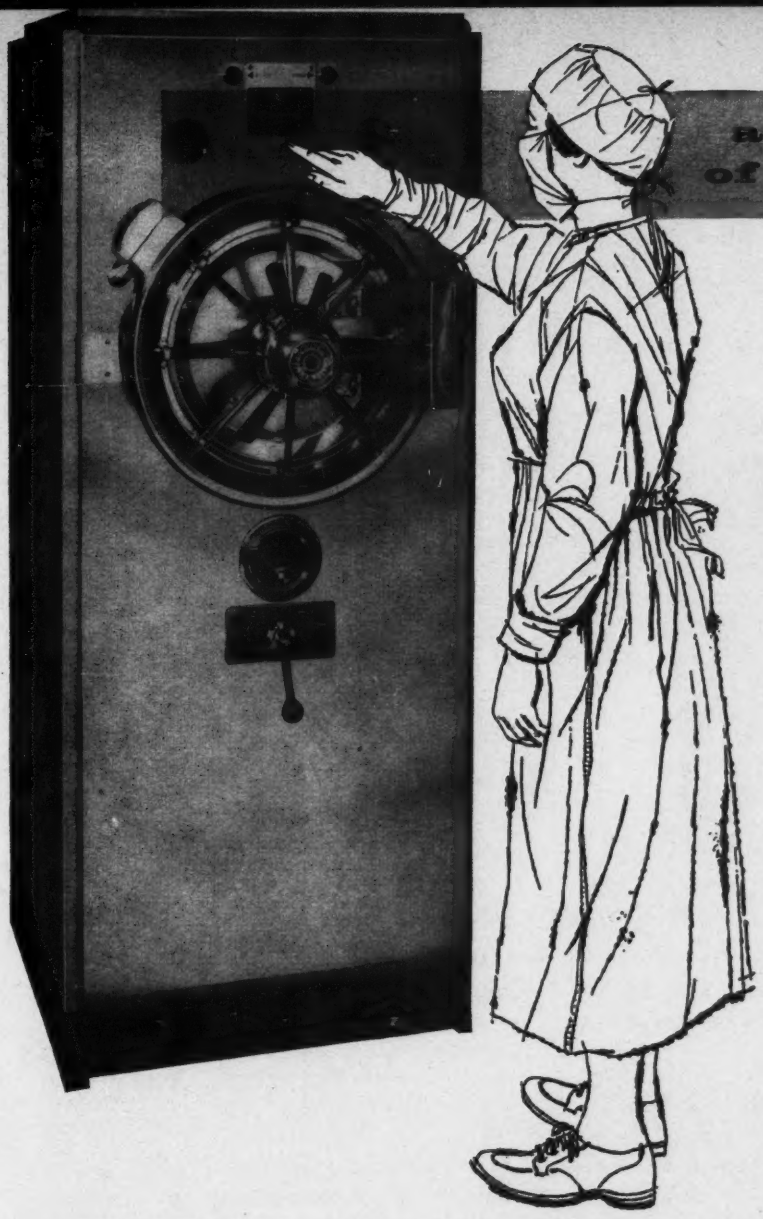
IN 1950, and for some time previous to that, St. Mary's Hospital was facing such problems as increased patient load due to an additional floor having been opened, shorter working hours for staff, eight-hour shifts for students, fewer available graduates and an increasing number of auxiliary workers. These factors had all contributed to the gradual adoption of an assembly-line type of nursing care which failed to provide for the individual and personal needs of the patient, and did not favour assignment of students in accordance with their training requirements. The nursing staff was frustrated and somewhat dissatisfied, and the turnover rate of nursing personnel was high. This situation was costly as the working time of the nurse who was leaving over-lapped that of the new nurse who was replacing her. A week or so of orientation was necessary before the new nurse was able to assume her full share of responsibility, and very often we had to hire private duty nurses — paying them private duty rates until they were replaced by another staff nurse.

First Efforts

In 1951 we heard about an experiment in patient-centred care which had been initiated in New York under the direction of Eleanor Lambertson of the Nursing Education division of Teachers' College. This experiment, at the New Delafield Hospital, was made possible through funds provided by the W. K. Kellogg Foundation. It was a plan for organizing nursing service on a team basis. We were immediately interested in the system and followed up all the reports on the experiment. We had also read with great interest the results of a study of the functional analysis of the nursing service team which had been made by Viola Bredenberg in 1949. The results of both of these studies seemed to indicate that teamwork in nursing tended to improve the quality as well as to increase the quantity of nursing service rendered. This plan seemed to be exactly what we had been looking for; and we decided to try it out. This was early in 1952. We held a few hasty conferences with our head nurses to talk over the problem. They frankly admitted that they knew nothing about the team concept but were willing to try it, although they were doubtful of its merits. We decided to try out the plan on one medical-surgical floor. We named the team leaders from among the group of graduates who were doing general duty nursing on the floor. The teams were organized with a student nurse and one or two nursing assistants working with each leader. Each team was responsible for about 16 patients besides having certain other responsibilities such as the care of the treatment rooms on their wing. Perhaps you can already guess what happened. We were so eager to find a solution for our problems that we had rushed into team nursing too quickly. Our head nurses had too little knowledge and understanding of the team concept. Our team leaders had not been carefully enough selected and they were not aware of the true meaning of team nursing. They did not recognize their responsibility for the nursing care of all the patients assigned to their teams, or for the guidance and assistance of the team members. Each person tended to work independently rather than as a member of a group with a common goal. As a result there was no co-ordination of the various activities. The team leader often took over the nursing care of the most acutely ill patients — leaving her little time to plan and organize with the other team members. Sometimes patients who did not seem very ill were left entirely to the care of the nursing assistant. Not having the education and training of the professional nurse, the assistant failed to note the significance of certain of the patient's symptoms, actions and behaviour patterns, and so nothing was done about them. We carried on in this manner for about a year, before we were convinced that there was no true understanding of the spirit and philosophy of the team concept of nursing. We decided that some of our key personnel should be given an opportunity to study team nursing as it was now functioning at Delafield Hospital and as Miss Lambertson understood it. Accordingly we selected one of our head nurses, a ward supervisor, and a clinical teacher to take the summer course that was being offered at Teachers' College. We hoped that these three would learn all about the team plan and how it should be organized, and also see it in operation. They were sent with the understanding that they would return to their present positions, and would assume the responsibility of instructing the rest of the nursing staff in team nursing. At the end of the 4-week course they returned full of enthusiasm and well indoctrinated with the principles upon which good team nursing must be built. They set about organizing an educational program aimed at helping the staff nurse to understand the essentials of team functioning. They held individual and group conferences and gave a series of formal lectures. They seized every available opportunity to help the rest of the personnel to understand the guiding principles and the nature of team nursing. They described team nursing as a co-operative venture wherein each member of the team performed her share of the work according to her preparation and abilities, and all members worked together toward a common objective. They explained that one member of the team more skilled and experienced than the others, would act as team captain or leader. She would be responsible for the nursing service of the patients assigned to her team. The team leader would generally assume the nursing care of one or two patients but would not overburden herself, saving time for the guidance and supervision of her team members. Nursing care would be planned so that a modified form of the case method of assignments would be used. The team leader would delegate the care of particular patients to the student nurse and to the nursing assistants who would assume whole or partial care of them, depending upon the amount of skilled professional or non-professional care required. In relation to the student nurse the team leaders would also consider the amount of learning and the status of the student and her educational needs. By late fall of 1953 we felt that most of our nursing staff had a thorough understanding of the team plan and were now ready to make it work. We decided to select our team leaders

(Continued on page 68)

From a seminar prepared for the 1955 summer session of the course in hospital organization and management sponsored by the Canadian Hospital Association.



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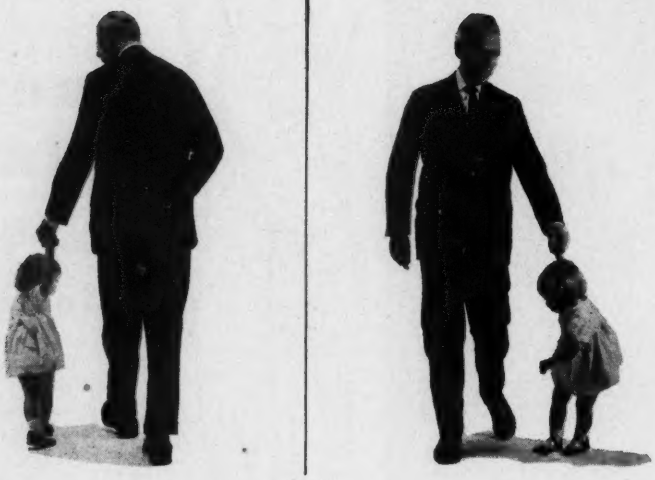

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V 11

Nursing Team

(Continued from page 64)

very carefully this time and to set up a model team using a medical unit of about 40 beds. We were so pleased with the results that the system is now in use on each of our medical and surgical floors with the exception of the private floor.

As Now Organized and Functioning

Each team is composed of a leader who is a graduate nurse or a senior professional student, one or two student nurses who are at various levels of their nursing course and one or two nursing assistants. The day teams never have more than 4 members. Each day-time team is responsible for approximately 20 patients. On the 3:30 shift the team consists of 5 members who are responsible for 40 patients and on the 11:30 shift the team has 3 members who are responsible for 40 patients. The patients are assigned to the team by the head nurse. The assignment is made on a geographical basis. Certain people, such as a head nurse, the clinical teacher and others —while not members of the team — are necessary and important to the team. The orderlies are not assigned to work with any particular team. The team leader will request the head nurse to send the orderly to assist her according to the needs of the patients assigned to the team.

The team leaders rotate on the various shifts. They work on the 7:30 shift for six weeks; 11:30 shift for two weeks; and the 3:30 shift for two weeks. When a new graduate comes on staff she spends the first day under the guidance of the head nurse or the clinical teacher who orientates her to the ward and instructs her on the general idea of team nursing. She is then assigned to one of the teams and works with them as a team member for at least four weeks. If she is considered suitable in temperament and ability she may then be named as a team leader. During the month that she is working as a team member she is kept under close surveillance by the team leader and has frequent conferences with one of the team co-ordinators who are guiding and assisting her to gain a thorough understanding of the team spirit and the special role and functions of the team leader. The success of team nursing depends almost entirely on the quality of leadership of the captains of the team and their understanding of team-relationships and the goal to be attained.

During the team leaders' six-week tour of 7:30 shift she is relieved for her days off by a graduate or senior student nurse who has been assigned to do relief work for that week. The team leaders have one day off a week and one week-end off per month. During the 3:30 shift of two weeks and 11:30 shift of two weeks, the team leaders do not have a day off. When they come off the 11:30 shift they have two full days off before going on the 3:30 shift on the third day. Following the 3:30 tour of two weeks they have five full days off. Two of these are for the two weeks of duty, two serve as their week-end for the month and the fifth is their day off for the week when they again start the day shift. The other members of the team get their days off for the week regardless of the shift they are working and are replaced by the relief nurse.

Daily Routine

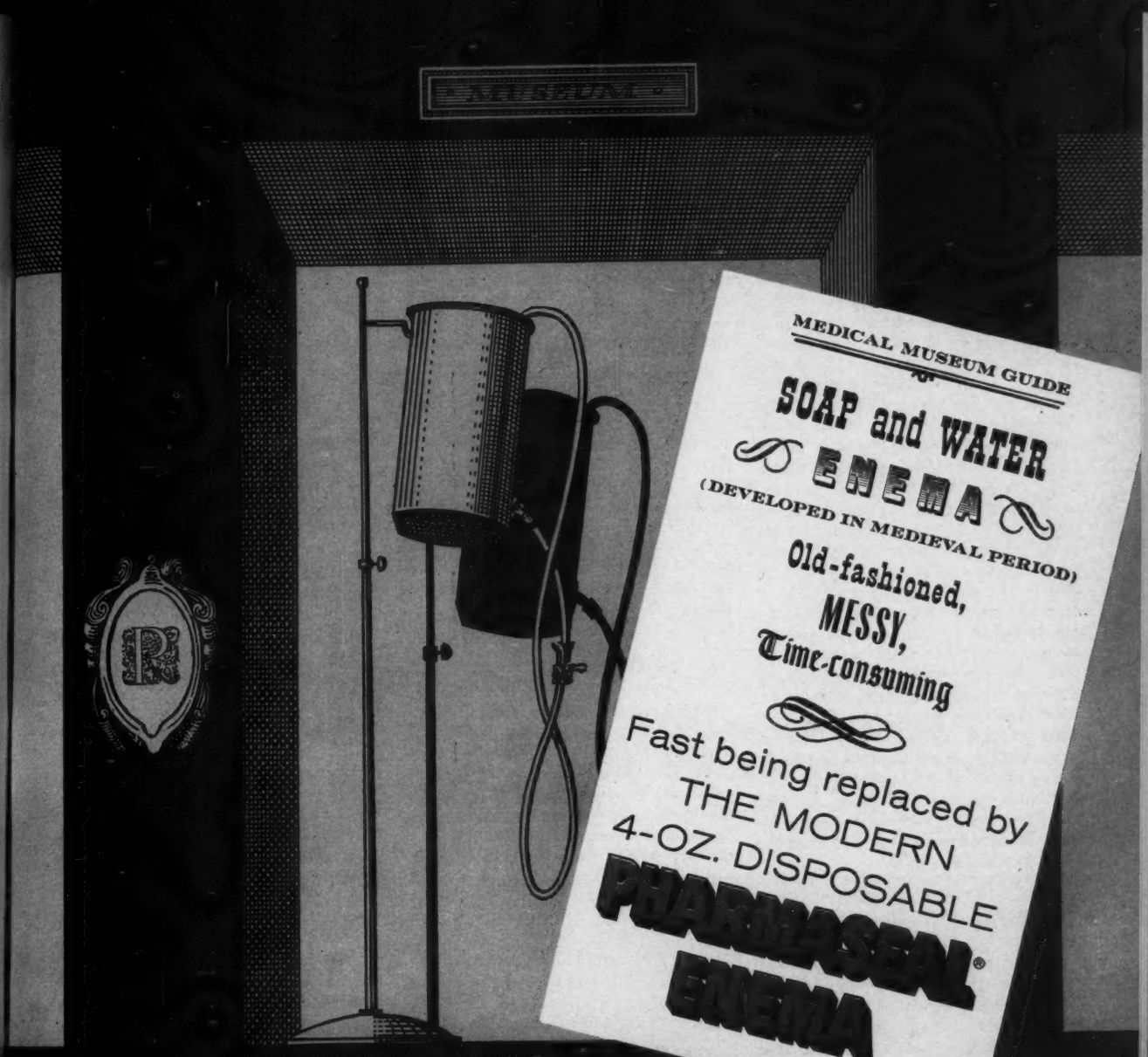
All team members assemble at 7:30 for the morning report with the exception of the nursing assistants, who spend this time preparing the patients for breakfast. During morning report, the leader makes notations regarding patients on her team and adds the names of new patients who may have been admitted after 3:30 the previous day. The assignment of patients to the teams is made by the head nurse. Following report, the team leader meets with the members of her team and goes over the assignment of duties which she prepared the day before following the team conference. New patients are added and assigned to the various team members. The assignment sheet shows the names of the team members, the names of the patients and the individual and group activities for which the team is responsible. The hour when each team member will go to her meals and the time for mid-morning coffee break are also shown. The use of such an assignment sheet enables each team member to know exactly what activities she is responsible for and enables the team leader to tell at a glance that all functions and duties of the team have been assigned. The listing of meal hours ensures that some member is on the unit at all times and that each patient will have constant supervision.

After breakfast is served, and while the patients are eating, the team as a group make rounds. They visit each patient and introduce themselves to the new patients. The patients look forward to these visits from the team. It gives them a feeling of belonging, and this adds to their sense of security. They know that each nurse on the team is interested in their welfare and progress and that they may call on any one of them to assist with their needs. We have not infrequently heard the patients speaking of "my team". The feeling of security which they now have, as compared with the old days when they were sometimes apprehensive lest they were being forgotten, or that the nurse might go off duty and forget to tell the next nurse what should be done for them, is quite noticeable.

After team rounds each nurse proceeds to carry out the work which has been assigned to her for the day. The nursing care plan for each patient is kept on a reversible card in an index file at the nurses' station. It is a lined card divided lengthwise into three sections. The first column lists the patient's diet, hours when temperature should be taken, if extra fluids are required, and amount of activity the patient is permitted. There is also a space in this column for special needs of the patient such as change of dressings, recording of intake and output of fluids, drainage of catheters, or wagensteen suction. The middle space on this card is reserved for notations regarding any special problems which have been observed or brought to the attention of the nurses, and the third column is reserved for the suggested approach to the patient's problems. This approach may be changed from day to day if the team finds that what has been suggested has not been effective. Facing the Nursing Care Plan card in the file is a second card which shows — impression, diagnosis, treatments, medications, special diet if ordered, and day and night report.

Every day at a time most convenient for the team — this is usually about 1:30 p.m. — the team leader and her team-mates assemble to discuss the nursing care of the patients on the team. This conference may last for 10 to 20 minutes. The time is not used for reporting activities, but rather for evaluation of the nursing care; discussion of special problems which have arisen with regard to patients; reports on the effectiveness of suggested approaches to problems; and for planning new approaches if they are indicated. The leader directs and guides the conference but is always careful not to dominate it. Each team member is encouraged to participate in the discussions, and we have often been pleasantly surprised at the observations and suggestions for better nursing care which have arisen from these discussions. When the group has decided to try a certain approach to a specific problem which has been presented, the team leader writes the method of approach on the nursing care card and it will be tried out on the patient. At the next conference or within a few days the group will discuss the results of this particular approach. These team conferences have not only proved valuable in helping the team

(Continued on page 112)



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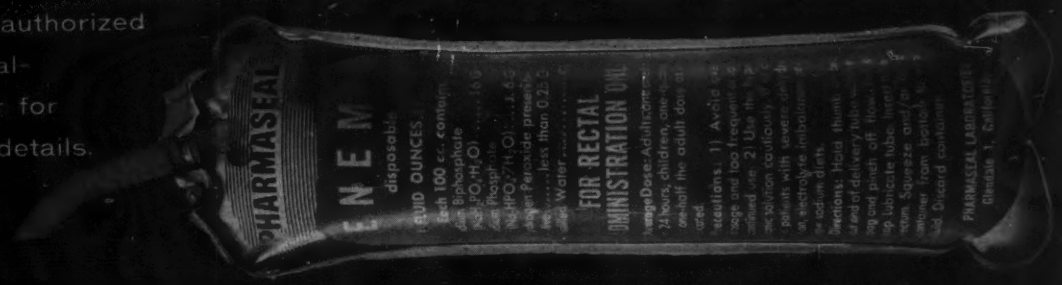

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The Women's Auxiliary of B.C. Division, Canadian Cancer Society, has started a new service for patients in the boarding home of the B.C. Cancer Institute, Vancouver. It is a mobile shopping centre which operates twice weekly to provide patients with the "little things" needed by those hospitalized. Proceeds go to the W.A.'s welfare and hospitality program which helps provide magazines for the patients, piped-in music, TV and an annual Christmas party. Services also include twice-weekly visits to patients when workers chat with them, write letters or do emergency shopping. Members of the hospitality committee are on call at any time to take patients to and from the clinic if necessary, and, when the weather is good, to take them on sight-seeing tours of the city. The 50-member organization also provides trained guides for conducted tours of the Institute and boarding home; maintains sewing committees to look after the Institute's linen, and has members working as volunteers in almost all departments of the Institute and the Cancer Society.

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Penny Bag Tea To Aid Crippled Children

The St. John's Guild, Winnipeg, Man., has taken on the furnishing and upkeep of the recovery room in the new Children's Hospital. One of their most successful methods of fund-raising is an annual "penny bag tea". This scheme started as a "violet tea" and the violet motif is still used in many ways. There is a booth where violets are sold, and violets are stamped on the tiny bags which are distributed each fall as invitations to the tea, which is held around Easter. A card accompanies the bag bearing a verse telling of the need for pennies to aid our crippled children.

• • • • •

Junior Auxiliary Great Help to Hospital

The Junior Auxiliary of the White Rock District Hospital, White Rock, B.C., known as the "Nightingales", continued its work through the summer months, with 2 of its 25 members going to the hospital each Saturday afternoon to assist with bed making, dressings, and other tasks. Biggest project undertaken by this junior group was the purchase of a heated bassinet for the case room. Part of the cost of this was raised at their annual tag day. The members of the group are high school students who are interested in nursing as a career. The Senior Auxiliary each year donates a bursary to one of the members to help finance nursing training.

• • • • •

Renovate Children's Ward

The 60 members of the Ladies Auxiliary to the La Verendrye Hospital, Fort Francis, Ont., have raised $850 for renovations to the children's ward. Another $550 was spent in the purchase of six inhalators. This money was raised through coffee parties, bake sale, raffles, membership dues and on Hospital Day.

• • • • •

Deer Hunting Fête
Annual Event of Auxiliary

The auxiliary in the village of Gunton, Man., sponsors a unique annual event for the raising of hospital funds —a "Hunters' Dance" which takes place at the close of the deer hunting season. A gun for a door prize draws many men to the event. Hunters are asked to save and tag the heads of the deer they shoot and enter them in the contest which is the main feature of the evening. A representative of the Game and Fisheries Association is the judge and prizes are awarded to the one having the largest head, the finest head, and the freak head. The winner owning the finest head gets a trophy engraved with his name to be held for a year and then turned over to the new winner.

• • • • •

Equipment for Hospital

A resuscitator machine for the nursery of the Bruce County Hospital will be purchased with the $2,000 derived from the Variety Fair held at Walkerton, Ont., by the members of the Bruce County Hospital District Auxiliary. The balance will be expended in obtaining a cautery machine and smaller equipment for fracture work.

• • • • •

Surgery Machine Given to Hospital

A machine used in different types of surgery has been purchased by the Ladies' Auxiliary of Cornwall General Hospital, Ont., at a cost of $800.

• • • • •

Hospital Furnishings Purchased

A total of $4,476 will be spent by the Hospital Ladies' Aid to purchase equipment for the new hospital now nearing completion at Portage La Prairie, Man. It was decided to purchase two stainless steel "meal-mobiles" designed for carrying 20 trays, and new linen for all of the hospital beds.

• • • • •

Transportation Problem

Faced with a staff transportation problem, the Auxiliary to the Ajax-Pickering General Hospital, Ajax, Ont., purchased and turned over to their board, an eight-passenger Volkswagen for the purpose of driving the hospital staff to and from duty. With the name of the hospital and the donors suitably inscribed on it, the vehicle also acts as a public relations conveyance through- an eight-passenger Volkswagen for

Examining the Women's Auxiliary gift of a rocking resuscitator to Prince Rupert General Hospital are, from left to right: Art Rutherford, hospital administrator; Mrs. J. L. Kelly, R.N., superintendent of nurses; R. G. Moore, chairman of hospital board; and Mrs. Richard Ayres, president of the auxiliary.

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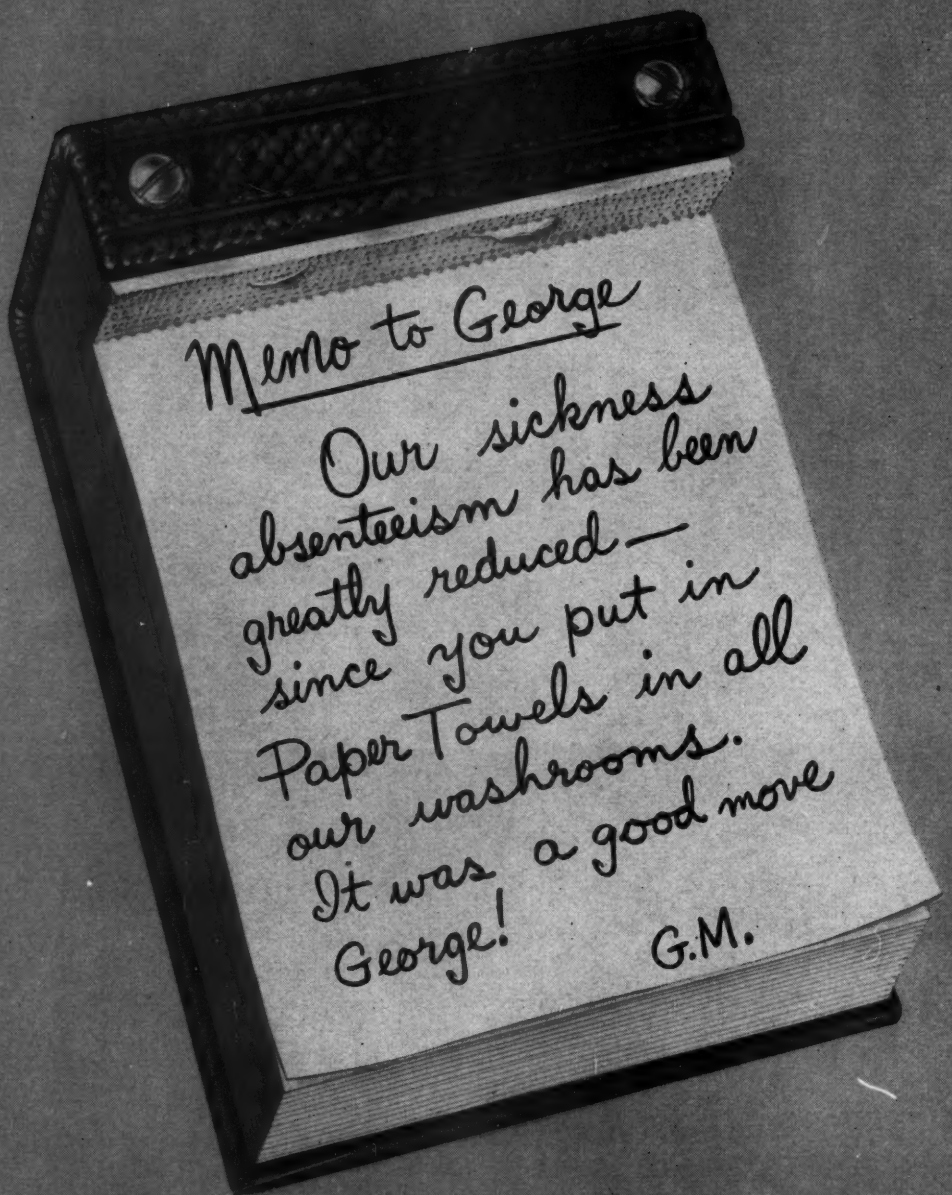

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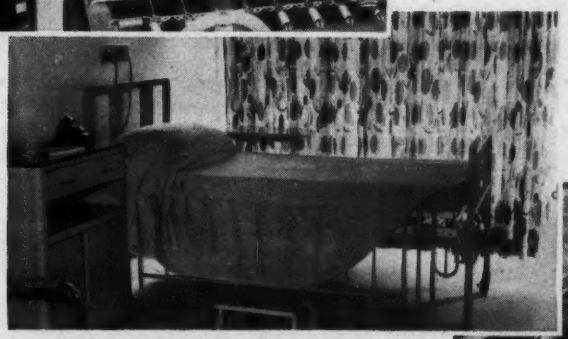

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Provincial Notes

British Columbia

BURNABY. Preliminary plans for the proposed 5-storey addition to Burnaby General Hospital have been completed by architects, Gardiner, Thornton, Gathe and Associates, Vancouver. The addition, to cost an estimated $1,250,000, will include new administration offices and laboratory as well as provision for 125 beds, 30 bassinets, surgical unit and enlarged boiler and laundry facilities. It will double the present hospital capacity. The proposed extension is the second phase of a four section master plan leading eventually to a 600-bed hospital.

CHILLIWACK. Preliminary plans for a $1,500,000 addition to Chilliwack General Hospital are being worked out by architects, Thompson, Berwick and Pratt, Vancouver. The new wing will increase capacity of the hospital to 135 beds with service facilities for a 150-bed institution. Present capacity of the hospital is about 100 beds.

GANGES. Planned at Ganges is a new hospital to replace the Lady Minto Gulf Island Hospital. Total cost of the project will be $272,485. The 24-bed hospital will be a one-storey concrete structure and is to have up-to-date facilities and surgical equipment.

NELSON. Plans for the new Nelson and District Hospital call for the raising of a 124-bed structure with 94 beds immediately available at the opening. Some 103 beds will be available simply by furnishing top storey wards and the balance available by finishing and furnishing 21 wards on the same floor. The total project is estimated at $1,800,000.

SARDIS. Construction of a new nurses' home at Coqualeetza Indian Hospital passed the halfway mark as crews almost completed the main structure. When finished, the home will cost about $100,000 and will house 30 nurses and other members of the nursing staff. The new home is the third major building to be constructed at Colqualeetza in the past four years. Earlier a new boiler room, laundry and a new wing were added on the grounds.

SURREY. A feature of the new Surrey Memorial Hospital is the double corridor design in which patients' rooms face outside walls, the operating and working areas being in the centre, to save travel time for nurses. The proposed hospital is to have three floors. The first section to be built will have 62 beds at a cost of approximately $700,000. Designed for easy expansion, when complete the hospital will have from 300 to 400 beds.

VANCOUVER. A new $600,000 6-storey wing has been opened at Mount St. Joseph's Hospital — a 152-bed hospital operated by the Missionary Sisters of the Immaculate Conception. The new wing has 32 acute care beds and 24 chronic.

Alberta

CALGARY. Tenders have been called for the construction of a $1.000 000 addition to the Calgary General Hospital. The addition will provide 40 more beds, making a total of 666. It will include a 6-storey tower at the front of the hospital and a 2-storey extension at the south side of the building for business and service areas. Architects are J. Stevenson and Associates, Calgary.

FORT MACLEOD. The Fort MacLeod Municipal Hospital is planning to construct a 31-bed hospital. Plans are for a one-storey building with a floor area of 19,000 square feet. It will be of frame construction.

MEDICINE HAT. Young fathers-to-be are going to have a comfortably furnished paternity rest room in the maternity wing of the new municipal district hospital. The room will be furnished in smart western style, the only room so adorned in the hospital. It will also contain iced water, plenty of ash trays, a rubber mat "pacing strip" and the latest magazines.

Saskatchewan

SHAUNOVAN. Shaunovan Union Hospital plans an addition to the nurses' home to be built at an estimated cost of $22,000. The two-storey addition will join the present nurses' home on the east side and will be of the same construction and material. The addition will double the bedroom accommodation, raising it from 8 to 16.

WAKAW. A new 14-bed Wakaw Union Hospital, built at a cost of $125,000 was opened recently. The new hospital contains x-ray facilities, operating room, emergency ward, laboratory and a nursery.

Manitoba

PORTAGE LA PRAIRIE. The new Portage District Hospital, Portage La Prairie, designed by Architects, Green, Blankstein and Russell, of Winnipeg, has been substantially completed, at a cost of $450,000. Plans also call for the establishment of a school of nursing at an estimated cost of $3,200.

Ontario

BRANTFORD. A five-year expansion plan, now nearly completed, is giving Brantford a practically new general hospital. The cost of the additions is estimated at $4,439,595. The five-year plan, to replace the original 70-year old main building and completely modernize the institution started in 1953, included three stages. The first was the building and equipping of a modern heating, power and laundry plant. This has been completed. Second step was the building of "A" wing, reaching to 12 storeys. It is made up of two pavilions, housing special services. One pavilion will contain the x-ray department, surgery, 6 operating rooms, psychiatric department, laboratories, and more than 100 service beds. The other pavilion, now mainly completed, will have a cafeteria, dressing rooms, and equipment facilities on the basement and ground floor. It will also house recovery rooms, maternity beds and parts of the psychiatric and surgery departments. The final step, one-storey "B" wing will contain patient beds. To make way for it, the old main building, kitchen, intern quarters, power plant and laundry will be torn down. The finished project will house 515 adult beds, compared with 334 beds at present. If further additions should ever be needed, five more storeys can be built on top of each of the two pavilions in "A" wing.

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You Were Asking . . .

AT THIS year's Western Canada Institute for Hospital Administrators and Trustees, a feature of the program was a number of question and answer periods. From these questions we have selected one and have asked administrators across the country to answer it in approximately 100 words. The hospitals represented range in size from 29 to 745 beds.

The question was: "Should the administrator spend much of his time in 'making rounds' or should the greater part of his time be spent behind his desk in order to 'be available'?" The answers received follow — *Edit.*

A FIFTY-FIFTY basis, with a leaning in favour of the rounds—that is, "Good Will" rounds where the administrator knowing his hospital may sense the general atmosphere, thus saving himself much office time by averting many a crisis.

However, this presupposes a good communications system whereby the administrator can be readily available on rounds. It also requires a two-way system whereby he is easily contacted and may contact the various departments while at his office desk—being careful to remain unswamped by detail. The over-all control is achieved by delegating responsibilities through the proper chain of command. — *Sister Mary Ruth, Superior-administrator, St. Vincent's Hospital, Vancouver, B.C.*

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PART of the administrator's job is to see that the work of the various departments is carried out efficiently, safely, expeditiously, and harmoniously. Staying behind his desk so that he is available, the holding of staff or department head meetings, or "making rounds", are devices or tools used by him to attain this objective. Just how much time is devoted to each activity will be dictated by factors such as, size of the hospital, type of service provided, physical layout and the degree of departmentalization of the hospital.

The administrator should be available for discussion with the superintendent of nurses and, possibly, the engineer, on a daily basis, preferably at a set hour.

In a 105-bed hospital direct supervision is possible and staff meetings need not be numerous. They should not be overlooked, however, and the administrator and department heads should meet at intervals of not more than six weeks. These meetings can be used to promote good inter-departmental relations and to establish satisfactory inter-communications routines.

Meetings at a similar interval of nursing supervisors and department heads with the administrator and superintendent of nurses can do much to promote smooth operation. For instance, feuds which may be developing between nursing supervisors and the laundry supervisor can be cured before they become chronic.

Making rounds is important. Incipient discontent can be uncovered and dissipated by personal contact. Violations of rules can be detected and stopped before they become widespread.

The administrator should plan his day so that the time at his disposal can be used to best advantage. Too much time devoted to one activity will reduce the amount of attention given to another.

He will find it necessary to adopt practices which fit his particular situation. — *Leonard Wilson, Administrator, Drumheller Municipal Hospital, Drumheller, Alberta.*

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THE best answer to this question is probably "both". Whoever asked it, must have had some particular local situation or circumstance in mind, which has not been included in the question, or else it was meant for discussion, rather than for a specific answer. Because, obviously, neither portion of the question can be answered by a simple "Yes" or "No". There must be a certain amount of "making rounds" and also a certain amount of sitting "behind his desk"; and the required amount of each will vary with different types of hospital, with different administrators, and from time to time, with varying circumstances. Valuable time can be wasted both ways. —*H. E. Appleyard, M.D., Superintendent, Regina General Hospital.*

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A GOOD deal of a hospital administrator's time will and must be spent out and around his hospital, meeting staff and patients, observing the activities of his hospital and getting first-hand impressions of problem areas. Formal meetings cannot substitute for this experience, nor can the passing of memoranda, though both in themselves are necessary.

In any year, however, the greater proportion of his time will find him either behind his desk or seated at the conference or committee table.

Look for him, too, behind the lectern in the hospital school, the high schools, the community dinner meetings and at the increasing number of hospital conventions and institutes. His secretary will always know his whereabouts; his wife may not.

In Western Canada in the autumn he is occasionally found at the edge of a waterfoul marsh; however, this will happen so seldom as to be of little significance in determining the occupational habits of this creature. — *Allan K. McTaggart, Administrator, Brandon General Hospital.*

• • • • •

IT is my opinion that an administrator should "make rounds". The patient is the first concern of hospitals and their (and their families') feeling of assurance is enhanced by our evident interest in their welfare. When "on rounds" I am able to observe the functioning of every department, coordination, the use and care of equipment, the medical and nursing staff, and students — their deportment and mental attitude — correct, advise, and encourage.

In my experience there is time for this, as well as meetings with our board of governors, and the avalanche of requirements which land in unceasing flow upon my desk. With the public address system I am available and at my desk within a matter of moments. — *Martha Nephew, Reg. N. Superintendent, Cornwall General Hospital.*

• • • • •

I WOULD state that from the small hospital standpoint, I think that the administrator must spend a good portion of time "making rounds". I believe also that these rounds should be made in conjunction with other duties while on each floor, thus creating a stronger and better feeling between patients, staff, and the administrative office. This time also allows for the administrator, if he so desires, to keep an eye on the general housekeeping, and maintenance problems which may arise from time to time. In many cases what might have been a serious mishap, breakdown of machinery, or what have you, has been attended to just because these rounds were made. — *Irene E. Mellish, Superintendent, Eastern Kings Memorial Hospital, Wolfville, N.S.*

(Continued on page 122)

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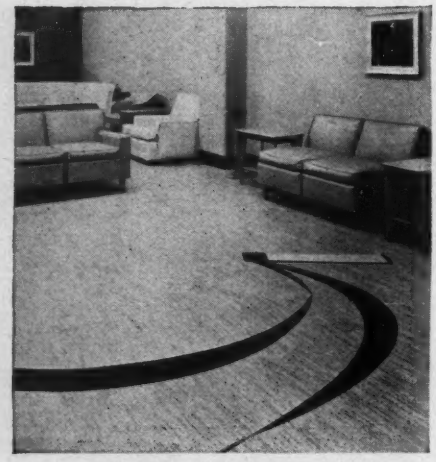

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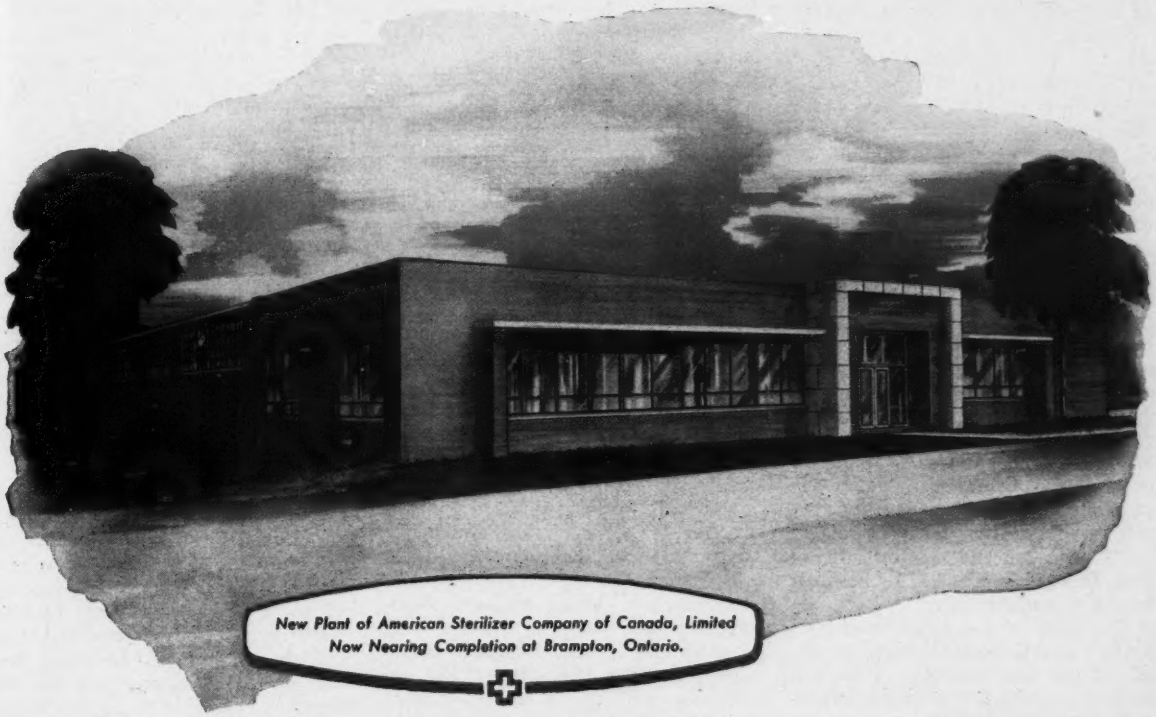

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— Through Motion Pictures

Kenneth E. Box,
Administrator,
Belleville General Hospital,
Belleville, Ont.

TODAY, hospitals are realizing more and more the value of good public relations. They are establishing planned public relations programs and are using every available medium to tell their story to the community. The majority of patients who enter our hospitals every day, and are returned to their homes to enjoy good health, have no idea what goes on behind the scenes, and the many services that are provided which contribute to their complete recovery. How can we best show them? Certainly, we can throw open the doors on Hospital Day, but in a great many instances we reach only a very small percentage of the community. If we cannot encourage them to visit the hospital, then we have to take the hospital to them. We think the best means of doing this is by motion picture film. Motion pictures are being used today quite extensively in industry for staff training, safety programs, and to advertise products. They are being used by hospitals, too, in a similar manner.

The board of governors of the Belleville General Hospital were cognizant of this fact, and they wanted to show the community what hospitals do and what they provide. Accordingly, they obtained a print of one of the many excellent films that are available and arranged to show this film to service clubs and organizations throughout the area. A speaker was also provided to give facts and figures about our own hospital. This film was well received, but not to the extent that we had anticipated. The board analyzed this situation and came up wih the answer that, whereas the film was excellent, it was not getting the message that we wanted across to the public. They realized that it was not showing people what we had. How could we do this? The obvious answer was to have a film made.

The cost of having this done professionally was beyond our means. Even if it were not, could we justify such an expenditure? The only other answer was to make the film ourselves. We had in our possession a 16 mm. camera with a 15 mm. and 25 mm. lens which had been purchased two years previously to record such events as sod turning, corner-stone laying, graduation exercises, et cetera. The difficulty was that there was no one in the hospital who knew anything about film production or script writing. We had long since decided that the film, if made, would have a story, and not be just a film shooting, from the kitchen, to the laboratory to the pharmacy. We wanted the production to be as economical as possible, yet at the same time, worthy of the hospital. We thought that we would have to have a script writer, a director, a photographer and one or two actors. Who could we get to donate their services? The local Theatre Guild was a possibility.

We approached Sydney C. Rose, a gentleman who has directed quite a number of plays for the Guild. He agreed to write the script and direct the film. Our next problem was a photographer. One of our local photographers had some experience with shooting this type of film and readily agreed to donate his services. He also provided the use of his equipment: flood lamps, tripods, et cetera. The director arranged for actors from the Theatre Guild to play the role of doctor, patient and nurse. All other persons appearing in the film are our own staff.

The script was written, approved, and the scene shooting schedule made up. The scenes were not shot in sequence, scenes which took place in the one location were taken as near as possible at the one time. For example, the outside shots were all made together — scenes showing the patient entering the hospital by ambulance and leaving the hospital after discharge, were shot at the same time. The opening scene was the last one shot.

As each magazine of film was exposed it was sent away for processing. On return, it was viewed to see whether the scenes were satisfactory, catalogued, and filed.

There are exactly one hundred scenes in the film. Some scenes which run from 60 to 90 seconds took as long as one and a half hours to shoot. In some case the scene would be rehearsed for an hour or more before the director was satisfied and the shooting took place. After the shooting was completed, the film was put together in sequence. This necessitated cutting, splicing and discarding of film that was unsatisfactory or not required. This is known as editing. To do the job correctly requires a viewing or editing machine, such as we were able to borrow from a local resident. We shot a total of 1,200 feet of film, of which 740 feet constituted the finished film, with a running time of 20 minutes.

Editing is important. If it is not done adequately no matter how good your acting, photography or story, you can end up with a poor film. It is necessary to be ruthless with scissors and waste basket. As may be seen, we discarded many feet of film.

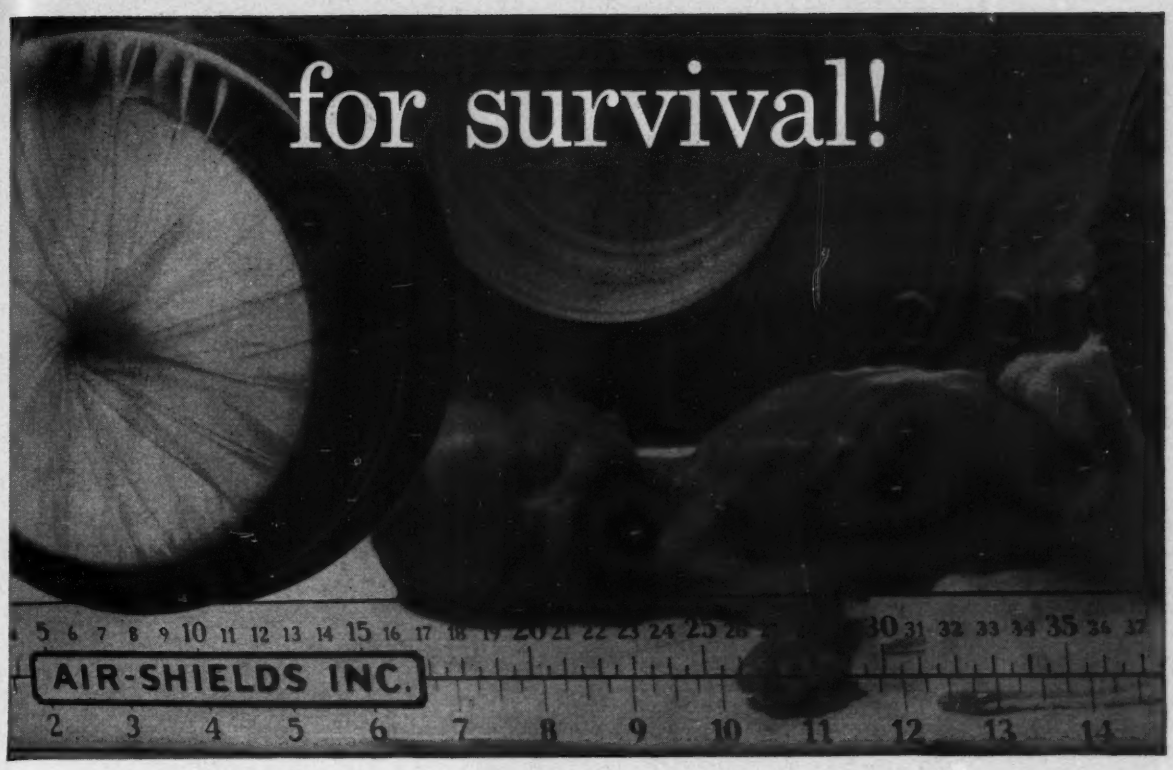
After the film was spliced a work copy was made by a film laboratory. The original film should never be run through a projector because no matter how careful one is the film will become scratched. The print cost sixteen cents a foot. The camera that we used was not equipped for doing "fade outs" or "lap dissolves", but the film laboratory was able to do this for us.

The next step was the sound track. It was our intention originally to do this on a tape recorder and run it in conjunction with the film to keep the cost down. This idea was discarded because it presented a number of problems; also, the film turned out so well that an expenditure of $200 to have an additional print made with a sound track was justified.

In making the sound track we enlisted the aid of the local radio station. A member of the staff of the local newspaper wrote the commentary, an announcer from the radio station did the narration. We used the radio station equipment to record the narration and musical score on plastic tapes. When this was completed, the tapes were sent to the film laboratory with the work print and another print was made with a magnetic sound track.

The total cost of producing the film was $556 that may be broken down as follows: film $180.00; work print $118.00; special fade-outs $48.00; finished print with sound track $210.00.

(Continued on page 98)



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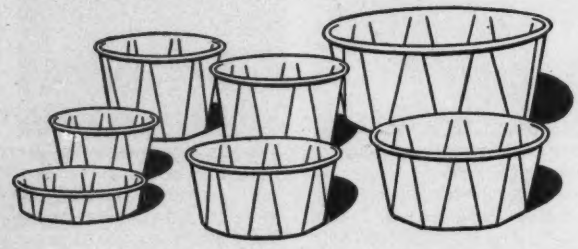

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The Significance of

Hospital Morbidity Studies

Gloria E. Whelen,
Research Assistant,
British Columbia Hospital Insurance Services,
Victoria, B.C.*

THE history of medicine is the history of research into the diseases which affect or afflict mankind. The primary steps in successful research have always been dependent on the accurate recording of known facts relevant to the prevailing diseases.

The study of the prevalence or incidence of disease in a given population — which in other terms is the study of morbidity data — provides the initial or primary source material for continuing exploration, control and prevention of illness in society. Morbidity statistics, accurately and carefully assembled and collated, can produce a quantitative opinion on the health of the community which can be vastly more acceptable to the medical research worker than the most reliable of personal estimations. Without the knowledge of the numbers of men, women and children of all races afflicted by specific diseases, combined with the information of when and how these people were affected and at what time in life, it is an almost impossible task to establish the continuity of progressive medical research. It is even more impossible to determine the fundamental impact that disease will have on the people of the community, the nation and the world.

In the past, this type of data has been supplied on a large scale but in an inadequate form, through the certifications of causes of death recorded by agencies responsible for the collection of vital statistics. It is hardly credible that inter-provincial comparison of vital statistics in Canada is only possible after 1926. Prior to 1920 even birth registration in Canada was not general. British Columbia has published vital statistics since 1893, but remote or earlier pathological or morbid conditions leading to death have only been recorded since 1913. The dread of epidemics of pestilential disease, such as cholera, smallpox, plague and yellow fever resulted in the reporting to a central authority, of the numbers of cases involved. The recording of the incidence of communicable diseases thus became the initial step in the application of control measures, such as quarantine. Today, these reports are used by public health officials to assist in the direction of plans for effective programs for the prevention of the contact and spread of infectious diseases. The routine reporting of communicable diseases has, among other results, disproved the efficacy of rigid, restrictive measures and has also provided material for publicity with which the public has been educated to the dangers of their health and lives. Because of the patient reporting and collecting of information, with respect to cause and source, today, communicable and infectious diseases no longer present the pandemic threat that once was inherent in their outbreak.

However, other forms of illness, often bearing fatal consequences, still stalk man as he goes about his daily affairs. It is these illnesses or injuries which cause such a tremendous loss to our society. The Workmen's Compensation Board reported that in 1954 the equivalent productive capacity of 3,000 workmen was lost in British Columbia alone — a loss which represented a withdrawal of $11,025,838 from the social treasuries.[1] When it is realized that this time loss was only the result of compensational accidents and did not cover unemployment from non-occupational sickness or disability, it will be envisaged how tremendous the sickness bill is in the province and in the nation. During the week of June 18th, 1955, 68,000 people of the total civilian labor force were reported as absent from work for reason of illness.[2] Is not this loss of economic strength, both physical and monetary, of concern to all those who have the knowledge in their hands to help improve all levels of hygiene? Improved reporting and collection of facts relevant to accidents and occupational disease must be the primary source from which research can be developed to reduce this economic loss.

Unfortunately, the toll of illness cannot be assessed in loss of wage alone. The National Conference on Appraising Family Needs published among their findings the following statement: "It has been generally observed that families with health problems are more likely than others to have problems of maladjustment, disorganization and delinquency."[3] It is certainly not a new idea that certain types of illness go hand-in-hand with backgrounds of poor housing, undernourishment, lack of education and insufficiency of medical advice. But it is a relatively new idea to track down socio-economic factors relative to the incidence of specific disease. It is only by the careful recording of data for individual diseases that these factors may be interrelated to point out the need for improved living conditions and in turn to improved health for the inhabitants of our communities.

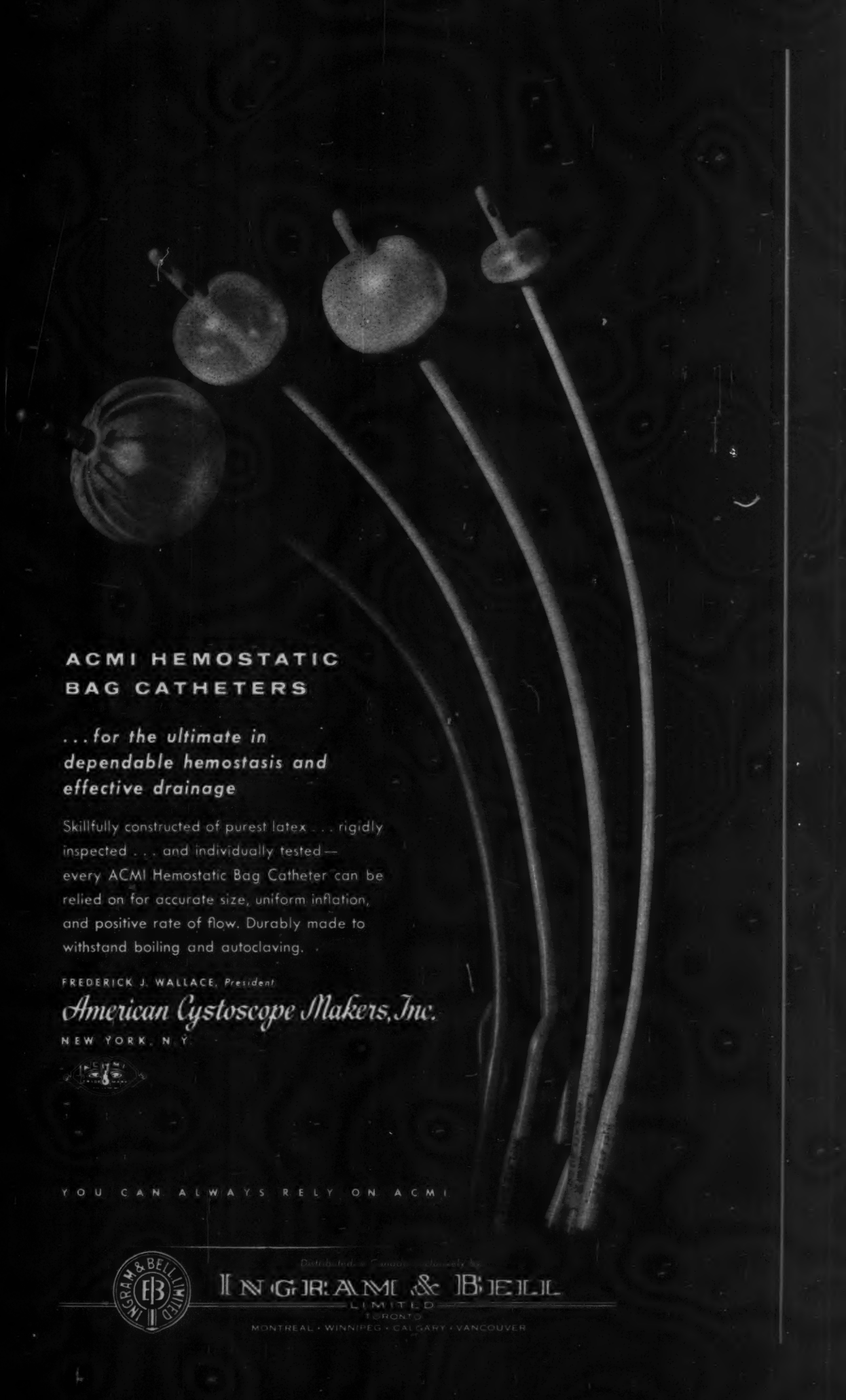
Illness among the aged is another field of research which is hampered by the lack of adequate source material. Men and women have greater chances of living to the proverbial ripe-old-age than ever before. In British Columbia the population is composed of a larger proportion of people in advanced age groups than is average in Canada. Combined with the fact that the length of life is spanning more years, this high proportion of senior citizens stresses the necessity for a comprehensive study of geriatrics, particularly here on the West Coast.

The lack of available material to assess the problems of sickness among the aged is only superceded by the lack of fundamental statistics on the incidence of chronic disease in our population. Chronic disease is perhaps one of the largest social problems which faces the research worker and the clinician today. The loss of earning power, which is concomitant with its occurrence, is of concern to economists while the cost of the care of those afflicted is the heavy responsibility of private and public welfare agencies.

The study of industrial hygiene, welfare problems, geriatrics and chronic disease is only in the formative stage but, each day, people in all community, national and international fields of endeavour are becoming increasingly aware of the necessity for

(Concluded on page 130)

*From an address given at the British Columbia Hospital Association's Convention, 1955.



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The Merits of an Appeal Board

G. W. Peacock, M.D.,
Registrar,
College of Physicians
and Surgeons (Sask.)
Saskatoon, Sask.*

THE term "Appeal Board" would appear to me to be self-explanatory, *i.e.*, a board or group of people so constituted to whom a person or persons could appeal with the object of clearing his or her name when charged with a misdemeanour or inefficiency, or with the object of correcting an unhappy and unpleasant situation. Such a board, when established, could have varying powers according to the dictates of the body establishing it. Its privileges could be mandatory or solely that of bringing in recommendations.

When I was with our present Department of Hospital Administration and Standards, (Department of Health), it seemed, due to situations of conflict met in the field, that such a board would have considerable merit. My present position strengthens this opinion.

Hospitals and their administration are complex and the only administrator who isn't constantly bombarded with a multiplicity of problems, and in contact with areas of conflict, is the one who is unemployed. The same thing may be said to apply to a trustee.

All of us who are or have been associated with hospitals are aware of these situations. In my particular field of interest the conflicts I hear of are mainly those in which a member of the medical staff is involved. These vary in complexity and severity, and also do the solutions. While my area of interest is primarily medical, I would wish to emphasize my sincere interest in total patient care and the rights of the community. I think you will readily agree with me that anything which seriously disrupts a hospital, and for which a solution is not soon found, will rapidly be reflected in these two areas.

In Smaller Hospitals

The situations met so far in this province have, in the majority of cases, involved smaller hospitals with their small medical staffs. Conceivably this could be due to the absence of an organized medical staff from which a board could obtain advice. Where there is a small staff, the organization we find in our larger hospitals is usually impossible or impractical. In the situations met with, it has been felt at times that certain physicians have had their privileges interfered with without good reason.

Obviously no objection can be raised when the action taken is justifiable, based on cause and in keeping with the severity of the misdemeanour committed. However, it is felt that in these situations personalities should not enter into the picture but, rather, what is best for the patient and the community should be the deciding factors. Here, it is quite true, opinions can differ.

With the idea of initiating some such scheme, the College of Physicians and Surgeons (Sask.), some time ago, advanced suggestions to the Hon. T. J. Bentley, Provincial Minister of Health, that it would prove advantageous to a hospital board, and the community which the board represents, to form an appeal group to which problems could be referred for a decision when their solution apparently was not possible at the local level. The Minister seriously considered this but naturally, since hospital boards were involved, he requested that the College discuss it with the Saskatchewan Hospital Association. This was done, but unfortunately the association executive at that time did not feel inclined to agree with our suggestions.

To the College it seems like a democratic and fair method of settling serious and disrupting problems before the community becomes involved. Such a board, if established, need not limit its investigations to areas of conflict between the medical staff and the hospital, but could include situations involving all other areas of conflict.

Some might feel that the inauguration of such a board, once its existence becomes generally known, would lead to a surfeit of meetings and sittings. I do not think that this would occur. The mere presence of such a board would have a salutary effect on all disputants by inducing them to arrive at their own solutions, because it would readily fix responsibility where it belongs. Thus a great deal would be accomplished towards the promotion of early settlements of areas of conflict at the local level.

Benefits

An appeal board, when functioning, would have a beneficial and educational effect of considerable value, both locally and provincially, because the thinking of the board would obviously be on a provincial level and by, presumably, qualified people of experience, all unbiased and all sharing a sincere desire to improve the standard of care to be made available to the residents of our province.

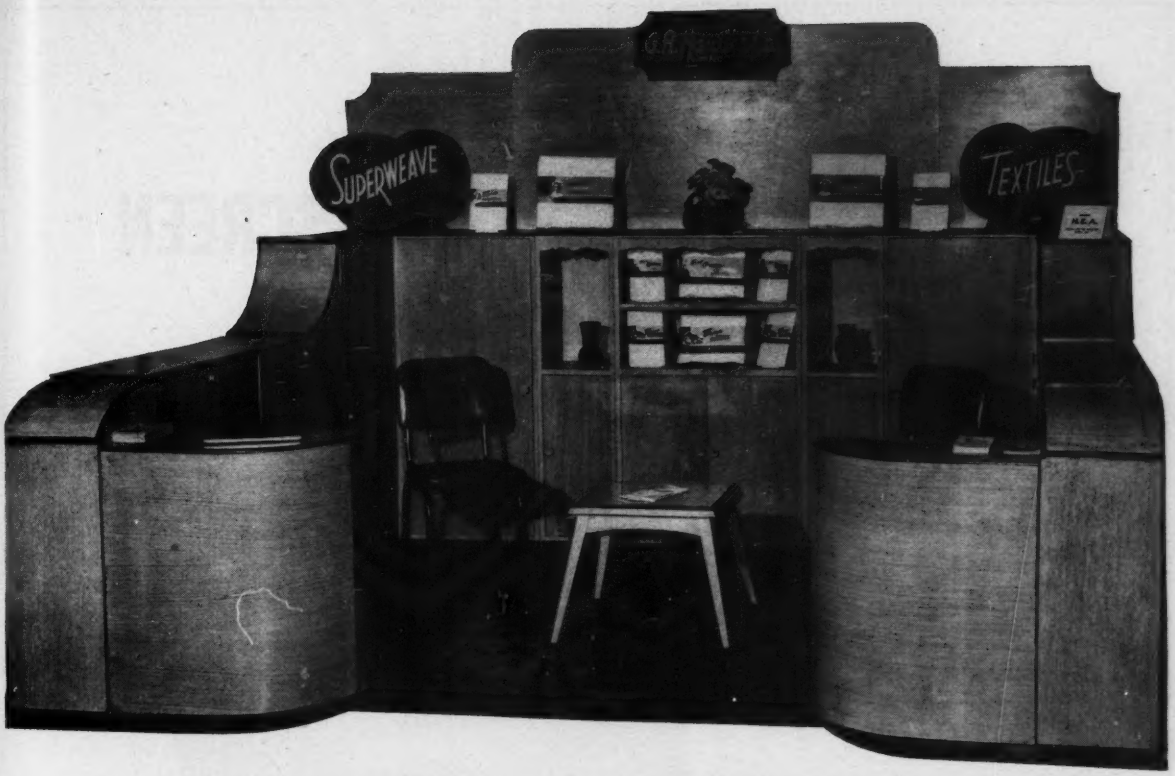
In Saskatchewan we have already had a "run down" or trial run along these lines in one of our best hospitals which became involved in a dispute with a professional employee and in which some few members of the community chose to involve themselves. Quite a fuss was raised prior to the board's formation.

On the invitation of the hospital board, an appeal or advisory board was formed consisting of representatives of the Department of Hospital Administration, the Registered Nurses' Association, the Saskatchewan Hospital Association and the College of Physicians and Surgeons, together with a representative of the community. I believe the members chosen all had a keen interest in the hospitals of this province and some particular experience or training to fit them for the position they occupied. Their function, in this case, was to bring in recommendations only. They had no mandatory powers. The board's deliberations were animated. Its criticisms were clear cut and constructive and I believe its proposals were effective. It did not legislate, but it advised. It had no power but it had influence.

I personally feel that we urgently need such an appeal board to give advice and assistance on request. In many of these situations feelings run high and personal animosities may lead to bitter enmities which sometimes spread to the community in such a way that the public interests may be lost from sight. In our hospitals we must strive for and maintain an atmosphere of mutual trust and co-operation be-

(Concluded on page 126)

**From an address presented at the annual meeting of the Saskatchewan Hospital Association, October, 1955.*



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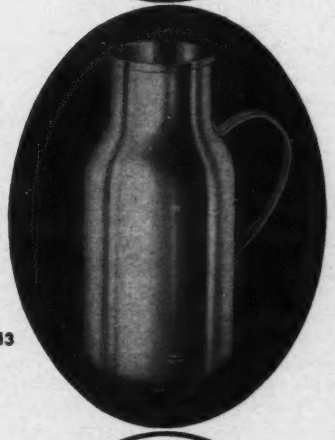

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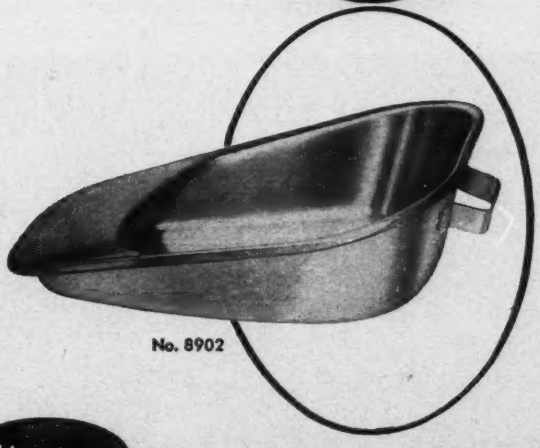

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First North American Conference of

Medical Laboratory Technologists

Ileen Kemp,
Hamilton, Ont.*

STORIED Quebec City which has been the scene of many history-making events was, in June, the site of the First North American Conference of Medical Laboratory Technologists. For the first time since their inception, the annual meetings of both the Canadian Society of Laboratory Technologists and the American Society of Medical Technologists were held jointly at the Chateau Frontenac.

Over 1,300 technologists from Canada, the United States, British West Indies and Europe were in attendance. The Conference Committee was co-chaired by the Executive Secretaries of both societies, Ileen Kemp of the C.S.L.T. and Rose Matthaei of the A.S.M.T.

Opening ceremonies held in Promotion Hall, Laval University, were chaired by Dr. J. Edouard Morin, professor of microbiology, Laval University. Among those bringing greetings to the conference were Dr. J. B. Bundock, representing the Minister of National Health and Welfare, Dr. A. R. Foley, representing the Minister of Health, Province of Quebec, Dr. Renaud Lemieux, president of the Canadian Medical Association, Dr. J. B. Jobin, Dean, Faculty of Medicine, Laval University, Barbara Isbell, president of the A.S.M.T. and Isabel Willis, president of the C.S.L.T. Following the opening ceremonies, a reception and tea were held at the Quebec Winter Club.

The scientific program was made up of four simultaneous sessions, three in English and one in French, held in the ballroom and committee room of the Chateau Frontenac and in the amphitheatres of medicine and physics at Laval University. So popular were these sessions that each one enjoyed capacity attendance. Seventy-five papers were presented by technologists from all over the United States and Canada, as well as one from Switzerland and the British West Indies. Highlight of these sessions was the opening lecture on Monday morning given by Dr. F. Kauffmann, chief of the International Salmonella and Escherichia Centre, Statens Seruminstitut, Copenhagen, Denmark, followed in the afternoon of the same day by a symposium of experts in the field of enteric bacteriology from Canada and the United States speaking on the subject of "Practical Laboratory Approaches to Enteric Disease with Special Emphasis on Cold Climate Aspects". Attending delegates had no difficulty finding subjects to interest them. Their trouble was to choose from the many valuable opportunities offered to further their scientific knowledge and stimulate an increased interest in their work.

The refresher courses offered were so popular that some were over-subscribed long before the convention dates. There were eight in English and one in French and they covered all fields of laboratory work. They were held early in the morning for two hours, from 8-10 each day, before the scientific program started. Enthusiasm was very high for this new feature and those who participated returned to their hospital with greatly renewed interest.

Instrument demonstrations constituted a further innovation. The flame photometer and paper electrophoresis were demonstrated and lectured on by experts in the fields. These demonstrations were each an hour in length. Both ran continuously and at the same time in different rooms, simultaneously

(Concluded on page 94)

Miss Kemp is executive director of the Canadian Society of Laboratory Technologists.

International participants in the medical laboratory technologists' conference: Front (left to right) — C. E. de John Van Beeken Donk, Holland; Elizabeth Pletcher, Switzerland; Isabel Willis, Canada; M. Sanguinette, Jamaica; M. Woodward, Hawaii; (left to right)—O. C. Young, Trinidad; F. Erlenmeyer, Germany; G. N. Khan, British Guiana; H. Zurcher, Switzerland; O. A. Best, Jamaica; B. Nef, Switzerland; Henry O. Fox, Jamaica.

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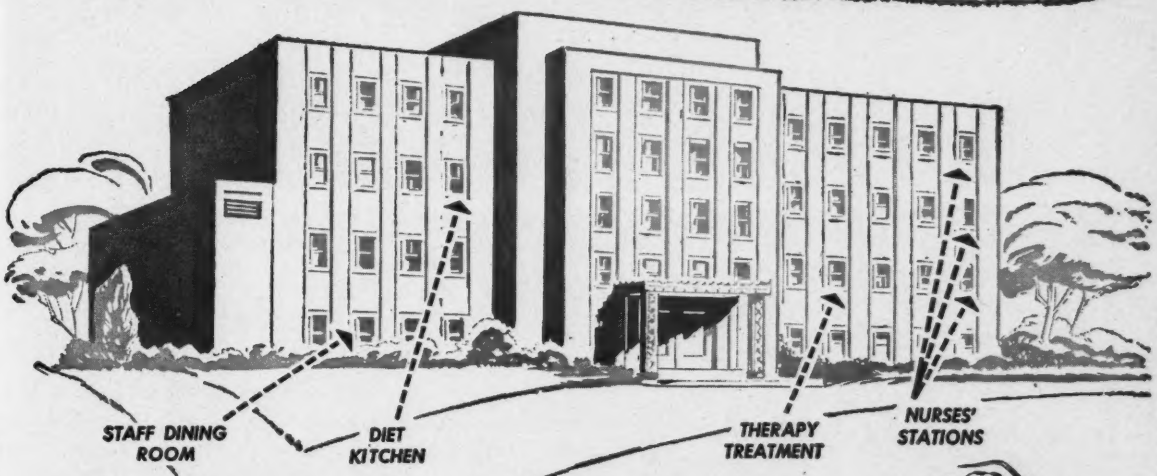

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Elizabeth Alexander, Calgary, Alta., newly elected vice-president, C.S.L.T. and J. R. Phythian, Niagara Falls, Ont., newly elected president, C.S.L.T., chat with Isabel Willis, Saint John, N.B., immediate past president,

with the scientific program, and delegates were so enthusiastic about them that they have asked for these to be included annually on convention programs.

Scientific exhibits of great interest included "A Clinical Laboratory Investigation of Coagulation Disorders", an exhibit showing "The Relationship of Respiratory Flora and Wound Infections", and a most interesting "Microbiological Safety Exhibit" which displayed and demonstrated safety devices used at the Biological Warfare Laboratories, Fort Detrick, Maryland, in their research program designed to protect laboratory personnel against infection hazards.

In addition to the above, 36 commercial exhibitors from all over the United States and Canada displayed the latest in laboratory equipment and supplies.

On the lighter side, the social events included a glamorous buffet put on by the Chateau's cuisine in true old world style with bustling white-hatted chefs behind tables groaning with foods as delicious to the taste as they were beautiful to the eye. The motif of the buffet table was a huge ice made by the head chef in the shape of a microscope, making everybody quite nostalgic for home and work. Provincial Branch luncheons were a great success with each province entertaining their share of American delegates in the hospitable way typical of that province. The city provided entertainment in the form of the "Changing of the Guards" and a concert on Dufferin Terrace by the Band of the Royal 22nd Regiment. On Tuesday evening, songs and dancing on Dufferin Terrace by "Les Villageois" drew large numbers into the dance, amid a great deal of fun and laughter.

A most interesting feature of the conference was a meeting, held Sunday night in the C.S.L.T. executive suite, of representatives of Societies of Technologists gathered from Switzerland, France, Germany, Holland and the British West Indies. The International Congress of Medical Laboratory Technologists was founded several years ago by a dynamic personality, Elizabeth Pletscher of Zurich, Switzerland, who chaired the meeting. This is the first opportunity the United States and Canada have had to meet with them officially, and the experience was a valuable one for the exchange of people in this field is on the increase all over the world.

Added to the charm of old Quebec, the opportunity for study, and greater international understanding, those of us who attended this conference found heightened pride in our chosen careers as well as in Canada. This was the result of the First North American Conference of Medical Laboratory Technologists.

Twenty Years Ago

("The Canadian Hospital", October, 1936)

Those of us closely associated with hospitals have so often heard remarked that the public ward patient enjoys many advantages usually denied the private patient. On one point, at least, this is undeniable. The large centre hospitals maintain complete laboratory facilities, an adequate and efficient technical staff . . . the use of this service is almost unrestricted in the case of the public ward patient. I realize full well that hospitals facing, as they do today, diminishing revenues and higher costs, cannot hope to extend the full use of such services to the private patient without charging especially for them. I am, however, strongly of the opinion that the hospital's service to private room patients should include certain routine laboratory service.

In most hospitals in our country the relations between the institution and the ministers of religion are for the most part cordial. More could be done if the role of religion in conjunction with therapeutic practice were better utilized. A more serious realization . . . might result in nurses being more exact about notifying ministers in cases of emergency . . . Free access to the sick, even outside of regular visiting hours . . . should be provided for the priest or minister . . . the moral and spiritual value of life should be emphasized more in the training of the nurse and shown in the administration and the practise of the hospital . . .

Salesmen and purchasing agents have one great thing in common; that is, the creation of good-will between their respective organizations. Confidence must be the greatest, though unseen factor in every transaction . . . When reading advertisements in hospital magazines it is significant to note the accuracy with which products are described . . . high sounding expressions are almost entirely absent and coupled with this the representatives who call upon the purchaser speak frankly of the limitations of their products.

At a meeting of the State Hospital and Medical League (Prince Albert, Sask.), it was decided to arrange for a provincial convention . . . bringing together all organizations interested in the state medicine movement, with a view to discussing ways and means of introducing the plan in Saskatchewan.

It is all right to say that public hospitals are for the acutely ill, not for the convalescent or the incurable, but what can the hospital do? Day after day, in almost every hospital in the land, the superintendent . . . waylays some visiting doctor to suggest the removal of some patient. And day after day comes back the same answer, "He might go out if we had a proper place to which to send him" . . . the first thing to do is to provide adequate alternative care—convalescent hospitals, hospitals for the incurable, home nursing services . . . until such time, hospitals will be seriously handicapped in their efforts to keep their beds open for the acutely ill. . . . ●

Nervous

A bishop walking through a village one day, called at a cottage for a glass of water. The old lady who brought it was nervous and to put her at her ease the bishop said: "This is beautiful water. Where do you get it?" The old lady replied. "From the Lord, my pump."

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Supplemental Oxygen in Newborn

Paul R. Swyer, F.R.C.P. (London),
Research Associate,
Hospital for Sick Children,
Toronto, Ont.

SUPPLEMENTAL oxygen is the one therapeutically effective agent available to reduce the 35 per cent to 50 per cent of neonatal deaths and residual brain damage due to respiratory difficulty and anoxia.

The physician is presented with a dilemma in that too much oxygen, in the premature infant usually involved, causes blindness due to Retrolental Fibroplasia (R.L.F.), whereas too little may be ineffective in relieving hypoxia. A re-appraisal of the physiological basis for supplemental oxygen is therefore necessary.

Respiration can be divided into two stages, the first comprising those processes by which oxygen is absorbed into the blood through the lungs and the second in which oxygen is made available to the tissues by arterial blood.

The lung processes in the first stage can be divided into total ventilation, distribution of inspired gases to the alveoli, diffusion across the alveolo-capillary membrane and circulation of blood through the alveolar capillaries.

In the normal individual, blood at the end of a pulmonary capillary will have reached equilibrium in regard to partial pressure of oxygen (PO2) with the gas in the alveolus at approximately 104 mm.HG. However, minor unevenness of distribution of inspired gases will result in some alveoli being hypoventilated or unventilated. This in effect, raises the pulmonary dead space. Blood circulating round such alveoli will therefore not be exposed to the normal 104 mm. Hg. PO2, and when eventually this poorly oxygenated blood mixes with the pulmonary outflow, the mean PO2 will be lowered to about 95 mm. Hg. (equivalent to 97.1 per cent arterial oxygen saturation - Sa02). This amounts to an alveolar-arterial O2 pressure gradient of 9 mm. Hg.

In abnormal pulmonary ventilation (A.P.V.) in the newborn this intrapulmonary shunt effect is much enhanced due to an increase in the physiological dead space up to twofold. A higher than normal alveolar-arterial gradient results. This gradient is still further raised by concomitant diffusion difficulty, which difficultv is aggravated by the increased diffusion necessary to supply more oxygen demanded by the increased respiratory work of dyspnoea. The net result is a raised alveolar arterial oxygen gradient in proportion to the extent of the pathological changes in the lung.

From limited observations so far undertaken using a Pauling oxygen analyser to sample the inspired atmosphere and a Wood ear oximeter to measure arterial oxygen saturation, it has been found that in the moderately affected case with A.P.V. the Sa02 is restored to normal by about 30 per cent oxygen or less. This corresponds to a P02 in the alveolus of approximately 170 mm. Hg. It may therefore be inferred that the difference between this and the normal alveolar P02 of 104 is the additional pressure head of oxygen necessary to reduce the physiological dead space — shunt effect, and to aid diffusion so that a normal Sa02 is achieved.

The second stage of respiration — the transfer of oxygen from blood to tissues — depends on the availability of oxygen in arterial blood. This is determined by the shape of the oxygen-haemoglobin dissociation curve, where degree of saturation is related to P02. In this connection I would like to put forward my concept of "Zones" of Pa-02. The "Safe Zone" corresponds to a Pa02 of between 80 mm. Hg. (95% Sa02) and 200 mm. Hg. (100% Sa02). Below 80 mm. Hg. is the "Hypoxic Danger Zone" where Sa02 and therefore availability of oxygen falls steeply. Above 200 mm. Hg. (about 35% 02) retrolental fibroplasia is increasingly common in the susceptible age and weight groups. This then is the "Hyperoxic Danger Zone".

The safe zone of arterial P02 can be achieved and maintained by supplying just that inspired percentage of oxygen which produces 95-99% saturation. By using the Pauling oxygen analyser and the ear oximeter the required percentage of oxygen can be supplied to avoid both hypoxic and hyperoxic danger zones.

Practically, limitation of oxygen percentage to below 35-40% virtually eliminates hyperoxic dangers (R.L.F.) and supplies more than enough oxygen to avoid the hypoxic danger zone in most cases. However, severe cases of A.P.V. may require considerably higher oxygen percentages to achieve a normal Sa02. Clinical assessment of cyanois is notoriously fallacious and measurement of Sa02 is the only reliable control in such cases.

Hypoxia in the newborn is of complex origin and cardiovascular factors may prove of major importance. Recent work shows that there is normally a high pulmonary artery pressure in the newborn period. It is known that one of the effects of hypoxia is to cause pulmonary vaso-constriction. Hypoxia could therefore cause a further increase in pulmonary artery and right heart pressures even exceeding systemic levels. In the presence of patent foetal passages (Foramen Ovala and Ductus Arteriosus) a right to left shunt could take place causing still further arterial oxygen desaturation and decrease in pulmonary bloodflow. In this way a vicious circle pulmonary hypertension could be initiated and maintained by hypoxia. It is easy to conceive of the importance of supplemental oxygen in preventing the hypoxic initiation of this cycle.

In summary, the physiological considerations underlying the effective and safe administration of oxygen to newborn infants have been reviewed and suggestions made for controlled therapy. It is evident that our knowledge is far from complete and much work involving difficult and sophisticated techniques remains to be done.

Reprinted from "The Bulletin" of the Toronto Academy of Medicine, with the permission of the academy and the author.

Motion Pictures

(Concluded from page 80)

The film took one year to complete, although such a job could be done in a much shorter period of time.

Was the time and cost justified? I will explain the response we have had and you can judge for yourself. The film had its première at the annual meeting of the Women's Hospital Auxiliary. That same day we had four requests for it to be shown to women's organizations. Since then it has been shown to twelve different groups and we have eleven bookings for the next month. We have received two letters from organizations which have seen it, stating that they appreciated seeing it and that the members now have a better understanding of their hospital. If any hospital would like to see the film, we will be glad to send it out on loan. •

Here and There

Social Geriatrics Movement

In 1610, a unique thing happened in history. The rich people of The Hague, Holland, established an old people's home in the city for their financially less fortunate older citizens. This was not a home, but a series of single stone homes adjoining each other and facing around a square. The garden in front of each home belonged to the occupant. The original buildings stand today and the program and plans continue as initiated in 1610.

It may be that The Hague's program stands unchanged and functional today because, by the act of allotting a bit of land to each, the 17th century Dutch recognized a bit of wisdom that is only now becoming apparent to the rest of the world. Henry A. Levine, consultant to New York City's Department of Welfare has built most of New York's program for older people around the fundamental belief that *activity* is basic in preserving a personality. His plan now serves as a model for most civic and religious efforts in the growing social geriatrics movement. — *Trends*

Flying Ambulance Service

In 1933 a doctor in Islay, Northern Scotland, had a dangerously ill patient on his hands. He knew that the patient could not stand the long journey to the hospital—miles away, by sea and rough road—but within a few hours he was able to arrange for the patient to be flown to Glasgow. From the experience of this doctor and others in remote areas, the Air Ambulance Service of the Highlands and the Islands of Scotland was developed. This air service has expanded considerably, being taken over by British European Airways when the National Health Service became effective in 1948.

When a local medical practitioner decides that a patient must travel by air he arranges for the patient's admission to the hospital, usually in Glasgow. He contacts the airport nearest the hospital and the details of the flight are arranged. Patients include the newly born, the aged, accident cases, surgical emergencies, maternity and gynaecological emergencies, medical emergencies patients with infectious diseases, and psychiatric patients. A nurse who has the required training is sent to care for the patient, along with a supply of the necessary equipment to meet emergencies. The patients generally appear to be little disturbed by the flight. Of the several thousand patients transported since the service began, only one has died in flight. One baby was born in the air creating a temporary problem of where to register the birth.—*American Journal of Nursing*

Informal Mental Treatment

A new unit for mental treatment called the Ashhurst Clinic has been opened recently in Great Britain. Patients suffering from the milder forms of mental illness will be referred to this clinic from other hospitals, and will receive treatment with no more formality than patients in acute and other types of hospitals, and not under the Lunacy and Mental Treatment Acts at all. The clinic can accommodate 60 patients, most of whom will be short-stay. They will be free to leave the clinic at will, without giving the prescribed notice. This will mean that they will be able to resume life at home and at work earlier than under the old system. In this connection, it has been pointed out that a quarter to one third of all the absence in industry was due to neurotic causes. — *The Hospital.*

U.N.K.R.A. Helping to Expand Nurses' School in Seoul

Funds which will help double the enrolment of St. Joseph's Nursing School in Seoul have been granted by the United Nations Korean Reconstruction Agency (U.N.K.R.A). The present one-storey building accommodates a maximum of 30 students living and working under badly over-crowded conditions.

Describing the project, Colonel Cecilia Kim, former Chief of the Nursing Corps of the Korean Army and now director of the Nursing School, has explained that "to date we have only been able to take girls for two years' training. That is too short. With the addition of a new building we can now give a three-year course and also bring the total of nurses in training up to 60."

As part of its training program, the school sends student nurses on rotation to other institutions specializing in treatment of various diseases. Four students have worked at the Han-No Children's Tuberculosis Hospital operated by the Norwegian-Korean Foundation, and others will go to the Ilsin Women's Hospital. A small general hospital is attached to the school.

U.N.K.R.A. has contributed to nurses' training programs in all parts of Korea including donations for this purpose to the Australian Presbyterian Mission at Taegu, the Maryknoll Sisters' clinic at Pusan, the League of Red Cross Societies for a tuberculosis hospital at Inchon, the Friends Service Committee at Kunsan and the Southern Presbyterian Mission at Kwangju. — *U.N. Department of Public Information*

Rag Business is Ripping Because Patients Aren't

Thanks to the effectiveness of the tranquilizing drugs, the 4,400 bed Ypsilanti State Hospital, Michigan, for mental patients now has to order its rags from commercial dealers. A department head recently requisitioned rags for cleaning, and was annoyed when the rags didn't appear. "Who's hoarding the rags?" he asked. Nobody was hoarding rags, it developed. Since the use of the tranquilizing drugs, the patients have not been "producing" rags from ripped-up clothes and bedding, a customary activity for 25 years. —*Scope Weekly*

More Doctors to be Trained

Three new medical institutions are being established in Pakistan in order to meet the shortage of qualified doctors, the government has announced. The three are an institute for post-graduate training of teachers in the basic medical sciences, a centre for post-graduate training of nurses, and a new medical college. The first two will be in Karachi and the third at Peshawar. Since Pakistan became a nation, the number of medical colleges in the country has already increased from one to six.

—*World Veteran*

A recreation and rehabilitation centre has recently been completed at Okinawa, to serve more than 100 sightless lepers.

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DESIGN • DEVELOPMENT • MANUFACTURE

Brandon Child Guidance Clinic

The Brandon Child Guidance Clinic, Brandon, Man., has been functioning for several years and has a good relationship with the Health Units and schools where it works regularly. It is a department of the Brandon Hospital for Mental Diseases of which Dr. Stuart Schultz is superintendent.

The Brandon Clinic does not go on the assumption that any child goes through childhood without being disturbed. "Every child at some time or other", says Dr. Schultz, "shows features for which children are sent to the clinic, e.g., temper tantrums, nervous systems, lying, stealing, aggressiveness, and so on. It is only when the disturbed behaviour is inappropriate to the child's age or is persistent and has not responded to the efforts of the parent, teacher or family doctor, that the child may require guidance treatment."

The following is a digest of the steps taken in the diagnosis of the causes of the trouble.

First, the child is referred to the Child Guidance Clinic by the public health nurse, parent, teacher, family doctor, or other interested persons. Prior to the child coming to the clinic, however, the public health nurse or clinic social worker visits the home and takes a detailed history not only of the present trouble, but of the whole of the child's development from birth. She gets to know the child's background, its relationships to its brothers and sisters and parents, and may even go into the parents' personal history. She may supplement this information from the schools, probation officers, and so on.

The child then comes to the clinic and is examined by the staff psychologist, who gives the child intelligence tests and personality tests of various kinds. If the examination is being held at Brandon, a routine brain wave recording and skull x-ray are also taken.

When all the data have been collected, the child is seen by the psychiatrist, and finally, a conference of staff members will outline what might be done to help the child.

Children who rate a low verbal intelligence on the tests, yet at the same time score well in other items, are given a thorough eye and ear examination. When eyes and ears have been shown to be normal, he is tested for laterality, that is, whether the child has achieved complete left or right handedness, or whether perhaps it is right handed and left footed, for these cases of mixed dominance may also have difficulty in seeing letters in the same way as another person, may tend to reversals, mirror writing and so on.

Dr. Schultz does not subscribe to the belief that every problem child is the result of a problem parent. The clinic has done a great deal of work with the disturbed child.

One of the problems that still remains is that some people consider that to attend a guidance clinic is a stigma. This can only be broken down by nurse or teacher and by the clinic itself, when dealing with parents. —*C.M.H.A. Report*

Confidence

When it is necessary for a young child to enter hospital, he should be given confidence but not deceived, if he is to stay there for a time. It is not a good idea to let him think the whole thing is just a picnic, since this may lead to a feeling of deception if he has any pain. He should be helped to understand that his visit to hospital is to help him to better health.

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Cracking the Language Barrier

The General Hospital of Port Arthur, Ont., has developed a multi-language booklet for mothers-to-be which explains each phase of hospital care from the moment the patient's husband leaves her at the desk to the arrival of the long-awaited baby. Utilizing this means of communication has proved to be one way of holding the attention of patients through a trying period. The information gained by the patients has helped to combat natural fears and create the highly desired atmosphere of relaxation so essential to the minds of maternity patients.

The article used, couched in simple terms to ensure complete understanding, was first written by Betty Gray, a student in the School of Nursing. (Miss Gray's article was published in full in the February, 1955, issue of the *Canadian Nurse*.) English-speaking mothers found it to be most helpful, but many new Canadians — those who might benefit most — still could not be reached unless an interpreter happened to be available. To overcome this language barrier the nursing staff of the obstetrical department decided to obtain written translations of the article and bind them together in a single booklet.

Members of the hospital staff, doctors and individuals in the community were approached for help. While many persons can speak foreign languages, surprisingly few can translate in writing. German and Finnish translations, however, were relatively easy to obtain. The latter now serves many nationalities, as most Swedish, Latvian and Estonian people can read it. A translation into the Ukrainian language was much more difficult to obtain, and eventually resort was made to a foreign-language newspaper publisher who could render the interpretation and type sufficient copies on a Ukrainian machine. This was necessary as letters of the Ukrainian alphabet differ so greatly from our own. The need for French and Italian translations has not proved to be great; however, work is now underway to produce copy in Polish and Danish. Comments from patients and doctors have been highly complimentary, and the booklet is now firmly established as a part of the personalized care program that the hospital strives to maintain.

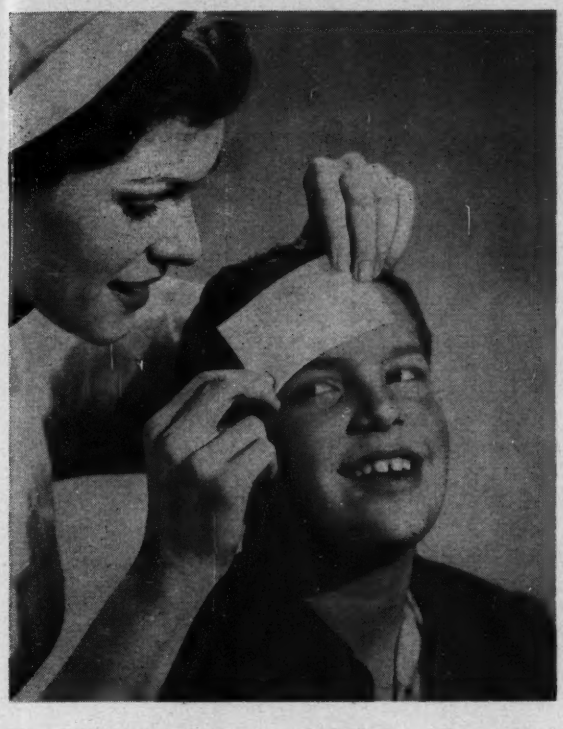
The information contained in the booklet has served to lessen apprehensions of expectant mothers, particularly those giving birth for the first time. Hospital and nursing routines are explained, followed by a description of the normal birth process. The latter has proved to be particularly valuable to foreign mothers, many of whom have stated their previous difficulty in understanding their doctors's advice due to language barriers.

Routine admission procedures are described in the booklet, and the various tests and examinations the patient must undergo are explained clearly and simply. Many times this simple effort to explain the unknown has gained co-operation from patients that would otherwise be lost. Following this section of the booklet, each of the three stages of normal labour is outlined in order that the patient will

(Concluded on page 120)

The author, Mrs. Jean Dawson, R.N., is obstretrical supervisor at The General Hospital of Port Arthur, Ont. This article is reprinted from Hospital Highlights.

OUT-PATIENT . . . OR . . . IN-PATIENT



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Bedlam

There existed in London in the thirteenth century an institute known as Bethlehem in which the insane were housed. The name Bethlehem was later abbreviated to Bedlam. In the eighteenth century lunatics were still kept in cages or chained to the floor. Bedlam was a London spectacle and people visited it for amusement, in the same way as they now visit the monkey house at the Zoo.

Nursing Team

(Continued from page 68)

to understand their patients as individuals and to consider their individual needs and thus give more complete nursing care; they have also been most useful in encouraging better communications and a co-operative group spirit among the team members and between the team members and other personnel, including the head nurse and clinical teacher. These two last named, while necessary and important to the teams, are not part of the team. They frequently attend the team conferences and, whereas they may offer suggestions, they must be very careful not to usurp the place of the team leader nor to permit the team to become dependent on them for solving the problems of the team.

Besides attending the conferences, the student nurses who are team members must also attend the clinics planned for them by the clinical instructor. The team assignment sheet, which is posted at the nurses' station, makes provision for this. These clinics are usually held every morning from Monday to Friday from 11:00 a.m. till 11:30. In order to ensure a well rounded experience for the student nurse, the clinical teacher, together with the head nurse, assigns the students to the various teams. The clinical teacher also goes over that team assignment with the team leader to make sure that the student is getting the proper type of experience.

All team members do their own charting with the exception of the nursing assistants. The team leader does the charting for the nursing assistants and is responsible for checking the charting of all other team members. The ward clerks are permitted to chart the temperatures of the patients.

With the exception of the administration of medications, all nursing care activities are carried out by the members of the team for the patients assigned to the team. Medications are at present the responsibility of a graduate nurse who is not assigned to any particular team, and who is responsible for the administration of medications to all patients on the floor — approximately 85 to 90 patients. In order that student nurses may have an opportunity to learn about drugs and methods of administration they are given a tour of duty as assistants to this graduate. There are a number of difficulties or problems associated with the administration of medications which have so far made us hesitant to make each team responsible for the medications of their patients.

Why We Like Team Nursing

The administrative personnel seem more contented and there is a noticeable decrease in the turn-over of nursing staff. Also there is an increased use of nursing assistants and better utilization of professional nurses' time. Both of these factors have meant an actual saving of dollars for the hospital. The public relations factor is exceptionally good and can be attributed in large part to the excellent quality of nursing care given our patients.

The Patient: all members of the team are interested in the patient's welfare and they consider the individual needs of each patient. The patient comes to know the nurses better and feels that he has someone in whom he may confide. He (or she) feels more secure in knowing that his care is the responsibility of a group of people who are being guided and supervised by a graduate nurse or competent senior student.

Head Nurse: many administrative details are assumed by the team

leaders thereby freeing the head nurse for broader planning. The head nurse has more time to observe and supervise the quality of nursing care provided on her unit. Fewer people are making direct demands on her time. Whereas with the old system every nurse reported directly to the head nurse, now only the team leaders need report to her. With this system she feels a sense of security in knowing that the patients' needs are looked after.

The Team Members: learn to work as members of a group and to co-ordinate their activities so that they are neatly fitted into the total pattern of patient care and other ward activities. All members are given an opportunity to work according to their individual capacity and education. The team leader has an opportunity to develop leadership and administrative abilities. The patient-centred nursing plan affords greater satisfaction and is more deeply gratifying to the nurse who is interested in her patient as a person and who can consider his spiritual and social needs as well as those of his body.

Students and Faculty: patient-centred care gives the student a better opportunity to practice the principles learned in her psychology and other social sciences. The student's assignments are more carefully planned and she progresses more readily from one learning experience to another. Time for the nursing care clinics for students is planned on the nursing care assignment sheet so that there is rarely any difficulty in having the students attend these clinics. If the clinical teacher finds an opportunity to do some special teaching with the students, she knows that the patients will be cared for by the other team members while the student is being taught.

Future Plans

We have thought of appointing one of our nurses who has had a special course in team nursing and who has helped to organize it on the wards as team co-ordinator throughout the hospital. At present there is a tendency to experiment with new ideas on different wards and this makes it more difficult for students and nurses to adjust when they are rotated from floor to floor.

We hope to prepare a formal course of lectures in "Team Nursing" and include this course in the block of studies given to our junior nurses. This year we gave a few formal lectures to the students who were taking their senior lectures.

We hope to place more emphasis on team nursing in our in-service program of education and to have our nursing aides and assistants attend conferences along with the professional nurses.

If we could find a way to avoid excessive traffic in the medication room at the hours when most of the medications are administered, we would like to have each team responsible for the administration of all medications to its patients.

Conclusion

Team nursing has helped us to provide a better quality of nursing care for our patients and, in general, our nursing staff seems to be happier and deriving greater satisfaction from their work. We would recommend this type of patient-centred care, but believe that at least the key people on the staff should be thoroughly familiar with the method of organization and philosophy of the team concept. It is clear that we erroneously persuaded some personnel that the system would not work, and prejudiced them against it from the start by trying to initiate it before it was sufficiently understood.

(Concluded on page 123)

New 1957 Hospitalization Tax Rates for Saskatchewan

Hospitalization tax rates for 1957 will be $20 for single adults, $40 for couples and $45 for families of three or more. An improved quality of hospital service, resulting in part from a better supply of hospital personnel, and the continued high utilization of hospitals have resulted in rising costs for hospital care in Saskatchewan as in the rest of Canada. These rising costs have made necessary an increase in 1957 hospitalization tax rates.

For single adults the new tax rates mean an increase of $5 from the present level of $15. In the case of families the maximum tax is raised to $45 from the 1956 level of $40. The $5 rate will continue in effect for children under the age of 18 years. On the family tax a minimum of $22.50 will be payable by November 20, 1956, with any balance falling due on May 31, 1957.

It is estimated that the new rates will yield about $11,300,000, or slightly more than half the present annual cost of the plan's operations.

For hospital care provided in Saskatchewan institutions, coverage of the Hospital Services Plan will continue at the same comprehensive level as heretofore. Services for which the plan pays in Saskatchewan include most services at the public ward level. The principal exclusions are extra charges for private and semi-private accommodation, most out-patient services, services of doctors and special nurses not employed by the hospital, and a few of the newer drugs.

Payments by the Hospital Services Plan on hospital bills incurred outside Saskatchewan will be increased at the beginning of 1957 to $10 per patient day from the present level of $7.50. The maximum period of care for which payment will be made to out-of-province hospitals will continue to be 60 days.

Since its inception in 1947 the Saskatchewan Hospital Services Plan has paid hospital bills every year for one person out of five. Taking into account multiple admissions — that is, more than one admission for some individuals — this has meant one hospital patient each year for every six persons. About one taxpayer in every three is concerned with hospitalization of himself or his dependents during the year. During the past nine years, the plan has provided protection against hospital bills for about 93 per cent of the total population of the province.

The financial support provided by the Hospital Services Plan has been an important factor in enabling general hospitals to expand their aggregate bed capacity in the last few years. Present bed complement in Saskatchewan general hospitals is 7.4 beds per 1,000 population, a figure very close to the goal of 7.5 beds per 1,000 envisaged in the provincial Health Survey Report of 1951.

Municipalities have also been affected by the existence of the Hospital Services Plan. Under legislation which has been in force many years, they are responsible for payment for hospital care required by their indigent residents. The Plan has made it possible for urban and rural municipalities to insure against such expense by paying the hospitalization tax on behalf of their indigent residents. — *Saskatchewan News.*

When the day of retirement arrives, the wise person will have hobbies or a substitute occupation ready to take the place of the old job. Sudden idleness after a busy active career may prove dangerous mentally and physically for the older person.

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Blue Cross in Canada Shows Increase in Membership

In a recent 1955 activity survey conducted by the Canadian Council of Blue Cross Plans, it is reported that some 228,724 Canadians enrolled in Blue Cross during 1955. This means that the total number of Blue Cross participants in Canada for the period ending December 31, 1955, is close to 3,500,000.

With an over-all increase in membership during the past year, the total number of participants for each Canadian Blue Cross Plan, as of December 31, 1955, is as follows:

Ontario	2,097,524
Quebec	603,856
Manitoba	358,099
Maritimes	292,826
Alberta	129,906

Approximately six hundred thousand hospital bills were paid on behalf of Blue Cross participants during 1955 totalling $50,295,441. Since inception, the five Plans have paid over four million hospital bills with a total value of $267,455,474.

The Blue Cross membership card is accepted in 6,000 hospitals on the North American continent; this simplifies admission to hospital, where the admission is in the subscriber's home town or away from home. A further simplification of procedure is made possible by the close relationship between the hospitals and Blue Cross—hospitalized subscribers' accounts are sent to Blue Cross, which pays the hospital direct, thus eliminating the need for the subscriber to file a claim.

Coming Conventions

Oct. 16-18—Associated Hospitals of Alberta, Macdonald Hotel, Edmonton.

Oct. 22-23—Catholic Hospital Conference of Saskatchewan, Saskatoon.

Oct. 21-23—Women's Hospital Auxiliaries of Ontario, Royal York Hotel, Toronto, Ont.

Oct. 22-24—Ontario Hospital Association Convention, Royal York Hotel, Toronto, Ont.

Oct. 24-26—Saskatchewan Hospital Association Convention, Bessborough Hotel, Saskatoon, Sask.

Oct. 25-26—Ontario Conference of the Catholic Hospital Association, St. Joseph's Hospital, Toronto, Ont.

Oct. 27-29—Canadian Association of Occupational Therapy, Montreal.

Oct. 30-Nov. 1—Manitoba Hospital and Nursing Conference, Winnipeg, Man.

Nov. 1-2—A. H. A. Institute on Operating Problems of Small Hospitals, Winnipeg, Man.

Nov. 26-30—A.H.A. Workshop—Developing the Skill of Supervision, Montreal, Que.

Dec. 3-6—A.H.A. Institute—Obstetrical Nursing Service Administration, Toronto, Ont.

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Chef de Cuisine, James Gilheany, of the Royal Connaught says: "My staff and I can speak only in the highest praise of the performance of our Garland Ranges and Broilers."

Equipment installed and gas supplied by United Gas Fuel Company, Hamilton, Ontario

The battery formation illustrated includes: Spectro-Heat Hot Top; Unitherm Fry Top; Deep Fat Fryer; and Side Fired Broiler. Units available in standard black-Japan or Stainless Steel finishes.

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People

(Concluded from page 26)

Ont., has succeeded Sister Consolata, who headed the hospital for six years.

• Dr. Charles F. Wilinsky, former executive director of the Beth Israel Hospital, Boston, and a former president of the American Hospital Association, has received the 1956 Distinguished Service Award of that association.

• Beverly Ramsey has been appointed nursing supervisor of the East Central Alberta Health Unit which serves 50,000 square miles. She will take up residence in Stettler.

• Dr. Madison B. Brown has been appointed to the newly-created position of director of administrative services for the American Hospital Association. Dr. Brown was previously medical director of the Hahnemann Medical College and Hospital in Philadelphia.

• Dorothy Doan, an assistant director of nursing service for the past three years at Toronto Western Hospital, Toronto, Ont., began new duties this month as administrator of Strathroy General Hospital, Strathroy, Ont., and also as director of nursing at that hospital.

• Mrs. Louella Wicks, Reg. N., of Wallaceburg and a 1955 graduate of Victoria Hospital, London, Ont., has been appointed head nurse in the obstetrical department of the new Sydenham District Hospital, Wallaceburg, Ont.

Two Short Films

Mental Hospital. This film documents the day to day story of a mental patient — from admission to discharge from the hospital. The story, one that dispels the many legendary fears associated with disorders of the mind and of "asylum" confinement, is projected from the patient's point of view. Hostile, confused, and depressed upon arrival, the patient gradually regains his ability to adjust to his surroundings. Through the help of a skilled medical staff working as a team, the patient finally can adjust to the outside world. The importance of proper treatment centres with adequate staff and equipment, as well as many little known facts concerning a mental hospital program, are effectively brought out in the film. *Mental Hospital* stands as an important contribution to public understanding. (Running time 20 minutes. Cost $95. International Film Bureau Inc., 57 East Jackson Boulevard, Chicago, Illinois.)

The Patient is a Person (Hospital Care). This film is presented by the Smart Family Foundation in co-operation with the American Medical Association and the American Hospital Association. The film explores the fearful attitudes which many patients exhibit on entering the hospital, and suggests techniques on non-medical care which may help to allay these fears and contribute to the patient's rapid recovery. It stresses the ways in which physicians, the admitting clerk, nurses, volunteers, administrative help and housekeepers can maintain the patient's confidence in the hospital team and fill his needs as a person. (Running time 20 minutes. Cost, colour $50, or $10 black and white, from either of the above organizations.)

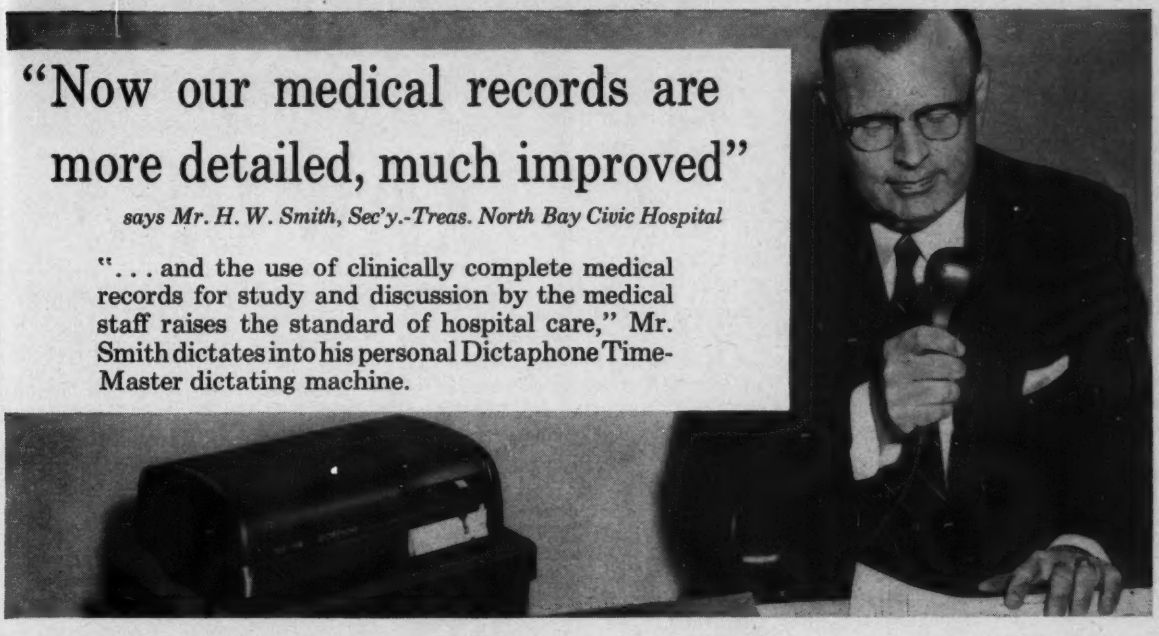
Failed to Pay Tax

A total of 15 Saskatchewan residents recently faced 48 charges of failure to pay the provincial hospitalization tax, it was announced by G. W. Myers, executive director of the Saskatchewan Hospital Services Plan. Fines and court costs in the 15 cases totalled $268.10.

"Now our medical records are more detailed, much improved"

says Mr. H. W. Smith, Sec'y.-Treas. North Bay Civic Hospital

"... and the use of clinically complete medical records for study and discussion by the medical staff raises the standard of hospital care," Mr. Smith dictates into his personal Dictaphone Time-Master dictating machine.



Various makes and types of dictating equipment were considered for the new North Bay Civic Hospital.

The Dictaphone Telecord system was chosen strictly on its own merit. Mr. Smith, Sec'y.-Treas. of the hospital, and staff physicians feel it gives them the greatest flexibility and the most advantages.

Dr. G. M. Wallace dictates his report immediately after an operation.

In the hospital, one central Dictaphone Telecord recorder is installed in the Medical Records office. Six Telecord phone stations located in the doctors' lounges and at nursing stations, are connected to the recorder.

Miss Watson, Librarian, reads a medical history to a doctor, using the system as an intercom.

To dictate his report, a physician merely picks up the Telecord phone and talks as he would into an ordinary phone. Control switches on his set enable him to (a) use the system as an intercom to confer with the Medical Records Librarian; (b) play back his last dictated remarks; (c) indicate corrections.

Staff physicians are most enthusiastic about the Telecord system. Incomplete longhand notes are eliminated. The convenient locations of the Telecord phone stations promote prompt recording of information while it is fresh in the doctors' minds. Because it is a closed circuit, dictated information remains confidential. Dictabelt records, small and flexible, cannot be erased—can be filed as permanent records.

Miss Brady handles all transcription of medical reports for 25 doctors.

Why not write for information about how a Dictaphone Telecord system can help raise the standard of medical care in *your* hospital?

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Hospital Administrators

(Concluded from page 62)

pitals operated by religious groups are deleted from the totals, the percentage of men to women is approximately equal in hospitals in the 50-99 bed group (Figure II).

In many hospitals in Western Canada it was difficult to determine from information available who the chief executive officer was. These hospitals, for the most part, list both a matron and a secretary-treasurer. While the pattern of administration varies, undoubtedly, from hospital to hospital, it is probable that in many of these institutions administrative functions are divided between the matron and the secretary-treasurer. In this survey, where there was doubt, and it must be admitted that doubt existed in many instances, the matron has been designated the chief executive officer.

Thirty-two different titles are used to describe these 1,042 chief executive officers; 275 are called superindent; 215 administrator; 159 matron; 98 superior; 81 nurse-in-charge and 81 medical superintendent. These six titles are used by 909 chief executive officers and represent 87 per cent of the total. There are two presidents, three director generals, two managers, and eight chief executive officers have a title differing from anyone else. Twenty-two are designated by a term usually denoting a departmental head but, to the best of our knowledge, they are the chief executive officers of their respective hospitals. In addition to those who are called superintendent, or medical superintendent, there are three general superintendents. The term "administrator" is sometimes qualfied also. In addition to administrator, there are two business administrators, three medical administrators, one general administrator, one director and administrator, three superiors and administrators — a total for the administrator group of 225 (see Table 5).

In a few large hospitals a multiplicity of terms, used in other institutions to describe a chief executive officer, was encountered. Some hospitals have a superior, an administrator, a superintendent, and a medical director. In such cases the division of administrative function, particularly between the administrator and the superintendent, cannot be ascertained from the title.

There are more physicians administering hospitals than is supposed generally; there are some 197, 115 of whom are in charge of governmental (federal or provincial) hospitals and 82 are employed in other hospitals (Table 6).

A survey of this type raises many questions which cannot be answered from information now available. We would have shown how many of the women are graduate nurses but we could not obtain this information with a sufficient degree of accuracy from our present records. We believe, however, that it is a very high percentage of the total. Other questions of interest would be the average age of the administrator at the time of appointment by size of hospital; education; experience; length of present appointment; and many other facts. Short of a specific questionnaire to all chief executives, answers to these questions are not obtainable. Knowing the average administrator's reaction to questionnaires in general, the writer has not thought it wise to burden the field with yet "another questionnaire" (see *The Canadian Hospital*, editorial, February, 1956, page 33). However, if many administrators indicate an interest, we would be willing to explore the subject further. Let us know your reaction.

Table 6

Medical Administrators

Location	Canada	B.C.	Alta.	Sask.	Man.	Ont.	Que.	N.B.	N.S.	P.E.I.	Nfld.	Y.T. & N.W.T.
Gov. Hosp.	115	18	10	9	12	24	3	9	6	2	22	0
Other Hosp.	82	7	6	4	4	21	25	4	3	0	4	4
Total	197	25	16	13	16	45	28	13	9	2	26	4

Language Barrier

(Concluded from page 106)

anticipate, then recognize, the natural events of childbirth. The activities of both doctors and nurses during the period of delivery are explained, again in terms that can be readily understood.

Judging from the favourable comments received from patients, doctors, and the obstetrical staff, this attempt to overcome the strangeness and fear caused by language difficulties has been successful and worthwhile. As a further service to our new Canadians, consideration is now being given to translations for use in preparing patients for surgery. ●

You Were Asking

(Continued from page 76)

YOU did not state specifically that in "making rounds" you refer to "seeing patients". I think that for the administrator to see patients is desirable but in a large institution is impossible. Someone from the administrative staff should see the patients, which is what we do in our hospital.

My opinion is that the administrator must make rounds of the hospital to keep in touch with department heads and the job conditions encountered by them. He must keep well informed regarding the physical plant in order to discuss intelligently matters with his staff from behind his desk.

I do not think one can be dogmatic and state the amount of time which must be spent doing one thing or the other, since this will vary so much with the size of the hospital and with conditions. — *Carl R. Trask, M.D., D.P.H., Director, Saint John General Hospital.*

• • • • •

I ENDEAVOUR to complete a tour of this 150-bed hospital daily, during which I visit all eight floors asking each head nurse and department head I meet, if they have any comments. I inspect toilets, bathrooms, janitors' rooms et cetera (in brief, the "off-the-beat" areas). I note defects or ideas in a notebook. If I am required in my office or elsewhere, my secretary has my number flashed on the doctors' visual call system. I am convinced the above is sound practice and have noticed that when pressure of office work has caused a two- or three-day interruption of these "rounds", a noticeable increase of my notebook entries has resulted. I observe also that department heads are encouraged by this personal visit. The above tour, if possible includes a brief chat with one or two patients who are well enough to comment on the hospital's service. —*Kenneth M. Nicholson, Administrator, Jeffery Hale's Hospital. Quebec City, P.Q.*

• • • • •

I AM of the opinion that the administrator should spend some time making rounds — for a 200-bed hospital at least one hour daily in one or more sections of the hospital. All patients should be seen by the administrator at least once during their stay.

If there is any single rule which has emerged it is simply a re-affirmation of the ancient edict that the health and comfort and peace of mind of the patient provide the reason for existence of the hospital. Who is in a better position than the administrator to assure the patient that he is among

friends who are personally concerned wih his welfare and that everything possible will be done physically and spiritually to restore him to health? We are re-discovering that every activity within the hospital must be concerned with the welfare of the patient. No matter how many beds your hospital has or how beautiful the architecture, or how brilliant the professional record of your medical staff, if concern for the patient is missing, your hospital cannot fulfil its responsibility to the patient nor to the medical profession.

You may have heard it said that the little extra attention given to a patient will create this important feeling of assurance. There is much truth in the idea. But I think we must remember that a rose on the breakfast tray is not nearly so important to the patient as a friendly "Good morning".

While making personal contact with our patients we are given the chance to see our personnel at work and an opportunity to understand their difficulties better. — *Sister Mary of Good Counsel, Administrator, Charlottetown Hospital.* ●

Nursing Team

(Concluded from page 113)

One of the most important principles which must motivate all members of the team is that the patient is at all times the centre and focus of all activities carried out by the team. The success of the plan will depend to some degree on how well the team members understand and accept this philosophy. Another very important factor which will determine success of the plan will be the capabilities and type of the person chosen to guide and act as leader of the team. She must be able to inspire confidence in others and to work with them so that all know and understand the common goal and have an opportunity to contribute toward the attainment of that goal. This type of democratic working situation under the direction and guidance of the right person as leader is bound to result in more efficient and more smoothly functioning nursing activities.

Before initiating the team system, try to sell the idea to those persons working in the particular unit where it is to be tried out. Try to get a group of nurses working on a small unit to volunteer for a trial period with the system. Never bring in outsiders to start the system if this can be avoided. Provide time for, and organize a regular in-service program. Don't be discouraged! Team nursing will not work miracles but if well organized and understood, it should solve some of your nursing difficulties. ●

Prov. Notes

(Concluded from page 74)

opened. It will replace the older building which has been in operation since 1926. Although the size of the accommodation as regards beds has not increased much — the older building has 35, while the new building has 41 —the facilities have been much improved, and will increase the hospital's efficiency.

KINCARDINE. The new $250,000 Dr. John McCrimmon memorial wing to Kincardine General Hospital has been officially opened. The new wing will increase hospital capacity from 32 to 50 beds. It contains kitchen, nurses' dining room, heating plant, waiting rooms, superintendent's office, admitting room, private and semi-private rooms, doctors' rooms, 14 nursery cubicles, and delivery room.

PENETANGUISHENE. Work is expected to start soon on a $2,000,000, 150-bed addition to the Oak Ridges Ontario Hospital at Penetanguishene. Aside from the patients' quarters there will be service rooms, medical examination rooms, minor surgery, and attendants' space.

Quebec

MAGOG. A new 100-bed hospital will be built at Magog and will be administered by the Congrégation des Filles de la Charité du Sacré-Coeur de Jésus. Existing hospital facilities in the area are not sufficient to meet the demands of the growing population.

MONTREAL. A phono-cardiograph has been presented to the Jewish General Hospital by the Jeanette Victor Memorial Group. The instrument will be used in the early detection of heart disease and to observe patients under treatment.

MONTREAL. Building plans for the Queen Elizabeth Hospital, Montreal, include modernization of the hospital's existing facilities and the construction of a new wing that will double the present patient accommodation.

MONTREAL. Construction of a new wing for the Hôpital Jean-Talon is expected to be completed by December. The new addition will give the hospital a total bed capacity of 154 beds and 25 bassinets.

New Brunswick

CAMPELLTON. Plans and specifications for the construction of a new wing on the east side of the Hôtel-Dieu St. Joseph's Hospital are almost completed. The project includes many changes and complete modernization of the present building. The four-storey structure will house new modern operating rooms, x-ray and a laboratory. One floor of the new wing will be used for making new and modern private and semi-private rooms. The bed capacity of the hospital will be increased from 190 to 250 beds.

MONCTON. Planned at Moncton General Hospital is an estimated $600,000 expansion program to provide a new nurses' residence and an extension to the laundry.

Nova Scotia

WOODSIDE. The 250-bed addition to the Nova Scotia Hospital at Woodside is progressing rapidly. Concrete footings and basements have been poured and work on the walls is now under way. The new hospital will be linked with the present hospital building by a tunnel. More than a year's work still remains to be done on the huge structure.

Appeal Board

(Concluded from page 86)

tween the staff and the administration. Without such an appeal board, when serious problems are not readily settled locally, public confidence in the integrity and efficiency of an institution, which incidentally may be the only one in a community, may suffer. An early settlement of a serious problem will maintain and retain public confidence for the hospital's future.

In all these problem areas mistakes have usually been made by several people. These precipitate conflicts and the sooner they are corrected and become past history, the sooner rehabilitation can be established.

All concerned must have an opportunity to become acquainted with the other fellow's point of view and his problems. In serious cases an outside point of view is often the best way of carrying this out. The appeal board would study each problem and could investigate and consider all these points of view, establishing contact with those in the dispute by means of teamwork and facts. Such recapitulation by the board is necessary for the lessons it can teach and in the understanding of the causes so that recurrence of such problems may be avoided in the future.

The cause of the trouble is usually due to a failure in human relations and the appreciation of all the sides of the arguments, frequently associated with a lack of desire to co-operate on somebody's part. In attempting a solution such adequate communication must be reached between the disputants so that emphasis can be placed on the area of agreement not that of the disagreement. I believe that in the case of failure to reach an acceptable solution at the local level, an appeal board is the only logical and democratic method and that those who are continually involved with these areas of serious conflict are in agreement with me.

Vacation Over

This year a neighbour of ours bought a new car guaranteed to hit 100 m.p.h. that he couldn't resist because the engine was rated at 250 hp. In two weeks with a car that fast he figured he could get pretty far from the daily drudgery. Couldn't resist giving her the gun at one spot on the road, so he revved her up to 75 m.p.h. Just made it past another vacationer, but on the other side of the hill there was this stalled truck that hadn't put out a flare . . . Our neighbour and his mighty machine ended in the ditch. The wreckage stayed there, but the neighbour was fortunate — he got out with skin and bones intact.

At his destination, a bit shaken and perturbed, he set right out on a sultry but beautiful day to play 36 holes of golf. He was exhausted, but a good swim fixed that up. A few cocktails and a seven course dinner topped the day off perfectly. (The night was slightly hectic . . . the chef had botched the cooking of the meat for dinner.) But all in all it was a wonderful two weeks.

Back home, our neighbour found his grass six inches high so he set right to work to shave it down. Certainly wouldn't let the fellow next door have the only neat lawn.

Work had piled up at the office for our neighbour, and to catch up he had to work nights, Saturdays and Sundays; before, during, and after lunches too. A few weeks after the delightful vacation a pain in the chest floored him. Nothing serious. He did well at the hospital, and was home again in two months. "The oxygen tent and those new fangled ideas of the doctors pulled him through."

"Yes, summer is a wonderful time." *(From Military Medicine, May, 1956.)*

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Lily's complete, matched paper service is the perfect, economical solution to hospital catering problems. More than fifty different cups to meet all requirements . . . full range of plates, including plastic-coated, non-absorbent line for hot foods and gravies. Lily service is economical, because it means an end to breakages . . . reduction in staff, because there's no dishwashing. A sure safeguard against cross-contamination, Lily is popular with doctors . . . nurses, too, because it's so light and easy to handle. Patients enjoy the gay, modern designs and absence of disturbing clatter. Yes, Lily's complete, matched paper service will revolutionize *your* hospital catering. For full information write NOW to: Dept. CH-1056.

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LILY CUPS LIMITED

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Emergency Services

(Continued from page 54)

and a 1,500 pound electric generator are also included.

Each hospital will be functionally packaged in about 250 wooden cases and the entire packed weight will be approximately 10 tons. The complete unit will occupy almost 1,400 cubic feet and can be easily transported in a moving van. The estimated cost of one unit is $25,000. The supplies will consist of only those essential items required to provide life-saving surgical and medical care. Supplies for this unit will be kept in first class condition at all times by means of special preparation for long-term storage.

In order to have the supplies available for rapid distribution to the many treatment areas within the hospital, packaging will be done on a functional basis. For instance, the beds, blankets, pillows, enamelware, and a limited quantity of drugs required for a ward, will be packaged in one set of boxes. These boxes will be identified by means of coloured corners and other special mark-up. In a similar manner the supplies for the operating rooms, the sterilizing room, the central supply room, which includes the pharmacy, will be functionally packaged.

When completed, these units would be placed in regional storage until required. They would never be placed in local storage at assembly points, but would be shipped intact directly from regional storage to the site of use, as the need arose.

The replenishment supplies for these units would be obtained through Civil Defence Health Supplies Service channels. The pharmacist acting as health supplies officer at the improvised hospital would request replenishment supplies through the local main control centre.

In conclusion, it must be emphasized that the improvised hospital is a practical survival unit which would be used only in cases of extreme emergency. It does not, in any way, preclude the present responsibility of hospital administrators, medical chiefs-of-staff, directors of nursing, and hospital auxiliary personnel to develop immediate, practical, and flexible hospital disaster plans.

Poliomyelitis Equipment, Niarobi

The most modern equipment available for fighting poliomyelitis has been incorporated in the new infectious diseases hospital, Niarobi, Kenya. The capital cost of this 290-bed hospital was £225,000. Oil-fired stoves and boilers are installed in the kitchens, and laundry equipment includes mechanical sterilizing, and washing machinery.

REGISTERED NURSES

PROVINCIAL MENTAL HEALTH SERVICES OF BRITISH COLUMBIA

Applications invited for staff and administrative positions for Psychiatric and Tuberculosis units in the Essondale area, which is on the outskirts of Greater Vancouver. These positions have been created through re-organization and expansion of the Department of Nursing.

Positions open:

Supervisors: for 225 bed Psychiatric and Tuberculosis unit.
Post graduate course in supervision or administration and post graduate course in Psychiatric and Tuberculosis nursing or equivalent experience.
Salary: $260. - $315. per month.

Supervisors: for Psychiatric units. Post graduate course in supervision and Psychiatric nursing or equivalent experience.
Salary: $260. - $315. per month.

Head Nurses: for Medical Surgical infirmary wards and Tuberculosis wards. Post graduate course in Psychiatric nursing or equivalent experience.
Salary: $255. - $287. per month.

Head Nurses: for Mental Health Centre. Post graduate course in Psychiatric nursing or equivalent experience.
Salary: $255. - $287. per month.

Nursing Instructors: for Training School.
Degree or diploma in teaching and supervision, plus experience in Psychiatric Nursing.
Salary: $255 to $287 per month.

Staff Nurses: for Medical Surgical wards and Tuberculosis wards.
Salary: $239. - $271. per month.

40 hour week, statutory holidays, 4 weeks vacation with pay annually. Residence accommodation in modern residence $5. per month, cafeteria meal service, 30c per meal. Recreational facilities. Applicants must be British Subjects and eligible for registration with Registered Nurses' Association of British Columbia. Apply to:

The Personnel Officer,
Civil Service Commission,
Essondale, B.C.

Morbidity Studies

(Concluded from page 84)

controlling and solving the riddles which illness and accidents present. Is it not quite amazing that in this age of statistics, when we know every ten years, how many head of cattle were grazed on how many acres of the Cariboo Census Division or how many board feet of timber were cut in the Nelson Forest District, we cannot readily obtain the number of surgical interventions for malignant neoplasm of the prostate?

There are now no reliable indices available to judge the growth of specific diseases and some must be devised if health standards are to continue to improve. If health problems cannot be solved, we as a nation will, of course, cease to grow strong domestically and internationally. The routine assessment of the health of the country should be vital to each one of us. Steps can, and should, be taken towards the establishment of reliable indices of the incidence of specific disease.

Hospital medical records *can* provide valuable material with respect to the incidence of hospitalized disease and injuries but, naturally, they cannot reveal the entire index of a community's state of health. Their value as a yardstick for measuring the need for further medical research is however, vastly significant.

Referring to the importance of the collection and compilation of morbidity statistics, the *First Annual Report* of the United States National Committee on Vital and Health Statistics included this statement: "Hospital records represent the largest existing body of medical information collected currently. Only a limited amount of statistical data is now being derived from these records."[4] I should also like to read you some lines written almost a hundred years ago. They are as follows: "I am fain to sum up with an urgent appeal for adopting this or some uniform system of publishing the statistical records of hospitals . . .I have applied everywhere for information, but in scarcely an instance have I been able to obtain hospital records fit for any purpose of comparison."[5] Florence Nightingale made that statement in 1860. Today, a uniform system of record maintenance is being established through the efforts of forward-seeking administrators, doctors and librarians. However, a uniform system can only be as useful as the use to which it is put. If this use is restricted to the administrative level, and the information is not made available for research into the cause and incidence of disease, the purpose of records is destroyed.

We are fortunate in this province in having a central repository for the admission-discharge records of each patient treated in British Columbia hospitals. The information which is now being extracted on a routine basis from your admission-discharge records is drawing the attention of public health and medical authorities in all parts of the world. It is realized by these people that the British Columbia Hospital Insurance Service is, for a relatively little addition to the cost of the routine processing of hospital claims for payment, able to establish the degree of specific hospitalized morbidity in a total population. In the past, conclusions concerning the morbid conditions existing in the total population have been drawn from surveys of sickness among a small, representative group of the people. No matter how carefully these statistical samples are drawn, the results have been subject to bias, which sometimes causes a distortion of the true facts. This distortion is primarily engendered by the reluctance to reveal certain information or the actual lapse of memory on the part of the interviewed population. On the other hand, hospital medical records are, or should be, a compendium of medical and irrefutable professional opinion. Therefore, they should be used by the statistician with the same confidence with which a physician uses his drugs.

The World Health Organization, in revising the International Statistical Classification of Disease. Injuries and Causes of Death, recognized the fact that comparable records of all countries would have intrinsic value to the health standards of the universe.

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Classified Advertising

Administrator Available

Twelve years in the hospital field in England. Was assistant administrator of Loughborough General Hospital in Leicestershire for over three years. Would accept post of assistant administrator. Box No. 837S, The Canadian Hospital, 57 Bloor St. W., Toronto, Ont.

Administrator Available

Graduate of CHA course in hospital organization and management, now employed as administrator JCAH approved hospital. Ten years executive management experience in Canadian hospitals with special training in accounting, finance and personnel relations; Member of AHA. Available for early appointment. Box 1019W, The Canadian Hospital, 57 Bloor St. West, Toronto.

Assistant Superintendent, Medical, Required

University of Alberta Hospital, Edmonton, Alberta, Canada requires Assistant Superintendent, Medical. Starting salary $7,800 per annum. Annual increments of $500 to $9,800. Give full particulars, name, references and enclose photograph first letter, to A. C. McGugan, M.D., Superintendent, University of Alberta Hospital, Edmonton, Alberta, Canada.

Medical Record Librarian

Excellent opportunities are available for two qualified Medical Record Librarians. Teaching hospital, good personnel policies, pension plan. Apply Superintendent, Ottawa Civic Hospital, Ottawa, Ontario.

Medical Record Librarian

Required immediately as assistant. R.R.L. preferred. Excellent personnel policies. Health benefits available. Apply stating experience and salary desired to Personnel Director, Sarnia General Hospital, Sarnia, Ontario.

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Administrative Nursing Personnel

For top level positions in top level hospitals in the United States and Canada.

Immediate need, Director of Nurses for leading hospital, Ontario. Also Supervisors Paediatrics and Obstetrics.

Excellent opening, Director of Nursing, New England and other Eastern hospitals.

Demand for Instructors increasing.

Dr. Johnson will be in Toronto, October 21 to 26, for personal interviews.

Writt New York Office to arrange appointment.

All enquiries strictly confidential.

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Mary A. Johnson, Ph.D., Director

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200 bed modern hospital with training school requires dietitian. Individual with general experience preferred. Salary open. Apply Lethbridge Municipal Hospital, Lethbridge, Alta.

Hospital Purchasing Agent

It is desired to appoint a Purchasing Agent who will act as assistant for approximately a year and one-half and then be prepared to take over the position of Chief Purchasing Agent. Salary offered commensurate with experience. If interested please apply to Dr. D. R. Easton, Medical Superintendent, Royal Alexandra Hospital, Edmonton, Alberta, stating your training experience and giving two references, as well as enclosing a recent photograph.

Director of Nurses

Director of nurses for 250 bed hospital with School of Nursing—suite in nurses' residence: full maintenance; good personnel policies. Apply, stating salary expected, age, qualifications, training and experience to Administrator, Union Hospital, Moose Jaw, Saskatchewan.

Dietitian Required

Qualified Dietitians for 445 bed hospital. Large Student School. New and modern Dietary Department, cafeteria and trayveyor service. Salary commensurate with qualifications and experience. Day shifts only. Liberal holidays, sick leave, pension plan and other perquisites. Excellent working conditions and quarters prevail. Transportation refundable after six months. Apply Director of Dietetics, McKellar General Hospital, Fort William, Ontario.

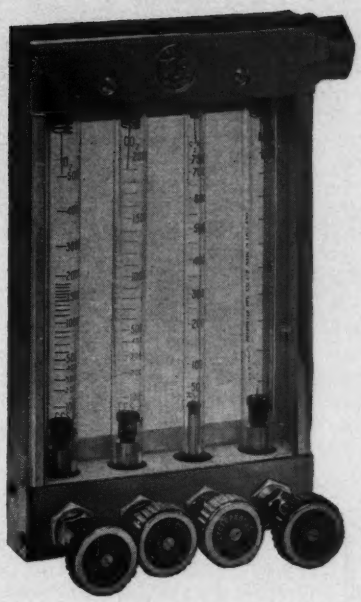
Dietitian Wanted

Opportunity for senior position in hospital planning construction of completely new kitchen and cafeteria. 285 beds with overall expansion program planned. Attractive salary. Apply: Administrator, The General Hospital of Port Arthur, Port Arthur, Ontario.

THE
KINGSTON GENERAL HOSPITAL
Requires
For Its New—81 Bed
Paediatric Section
A PAEDIATRIC SUPERVISOR
and
A PAEDIATRIC INSTRUCTOR
For Further Information write to:
Director of Nursing,
Kingston General Hospital,
Kingston, Ontario

Medical Records Librarian

Registered Librarian to take complete charge of Medical Records Department of 445 bed accredited hospital. Well organized and staffed. Dictaphone service. Salary commensurate with experience. Excellent working conditions. Transportation refundable after six months. Apply R. V. Johnston, Superintendent, McKellar General Hospital, Fort William, Ont.



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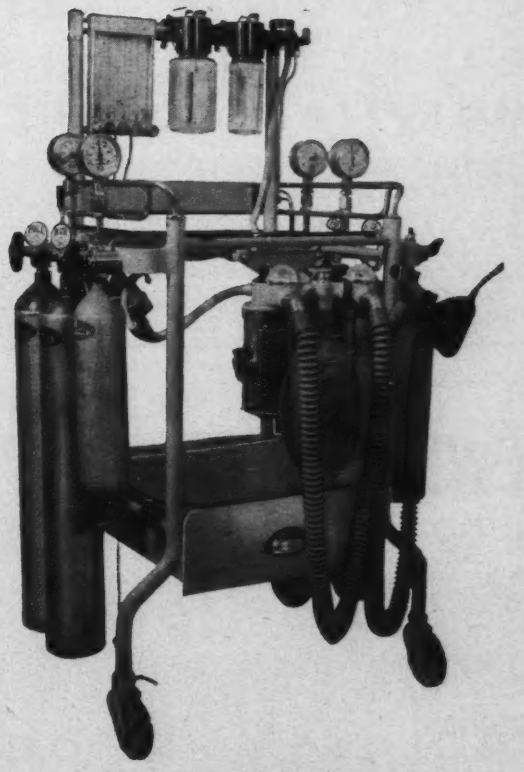
THE QUADRUPLE ROTAMETER UNIT

A standard unit on all Boyle Anaesthetic Machines. A unique feature of the Rotameter is its "vaned" bobbin which rotates about its vertical axis. The upper rim, which is the flowrate index, has several diagonal grooves which cause the bobbin to rotate in the upward stream of gas. This rotational movement has the effect of keeping it in the centre of the stream and friction with the wall is thereby eliminated. Consequently, there is no wear and accuracy of the instrument is at all times maintained.



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(MEDICAL DIVISION)

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Oxygen: Oxygen Carbon Dioxide Mixtures: Nitrous Oxide: Cyclo propane; Carbon Dioxide: Helium: Helium and Oxygen Mixtures

Public Health Awakening in Israel

Many unique public health problems plagued the new state of Israel during the past eight years. After the barriers of immigration were let down, persons from 85 different nations started pouring in over its borders. This little land soon gathered a confusing mixture of languages and strata of culture. There were persons from the Anglo-European countries who represented the epitome of high cultural development, and there were others, from the Khourdistani regions, who were pitifully primitive. Too many of the latter groups were indigent, malnourished, and ignorant of sanitation. Their problems were so acute that it was imperative to solve them as quickly as possible, since in their large numbers, they constituted a direct threat to the economy and health of the country.

As a result, two main agencies began to devote themselves to these groups, namely "Kupat Cholim", a government-sponsored program, and "Hadassah", a voluntary group. Together, they combined their efforts to help the newcomers convert themselves into healthy well-adjusted citizens. Both "Hadassah" and "Kupat Cholim" societies employ public health nurses. "Kupat Cholim" concentrates on treating the immediate ills of the sick. "Hadassah", which also devotes itself to the remedial side of medicine, has forged ahead with some effective forms of public health teaching. One of their projects is the pilot study taking place in a little newly-formed community outside of the environs of Jerusalem, called "Kiryat Hayovel".

This community of 1,400 families was built less than three years ago, with the express purpose of housing families from at least 40 different countries of the world and to provide them with a community health centre which would consider total patient care. The project was built close to the new Hadassah Medical Centre, where it could be the object of study for everyone in medicine and its related fields.

The personnel numbers six general practitioners, one clinical pathologist, seven nurses, one social worker, one laboratory technician, two health educators, and a part time physiotherapist. The staff is divided into separate medical teams, each of which functions as a unit for the families assigned to their care. Each team also conducts weekly conferences when specific family problems are brought to light. The anthropologist's contributions are invaluable at these meetings because he is able to define for the staff the ethnic problems of these people so that they can be met with levity and understanding.

Aside from this pilot study, there are a great many other types of public health care. Israel has Mother and Child Welfare stations all over the country which boast of very close follow-ups by both the doctor and the nurse in the homes. There is also a Visiting Nurse Service in the major cities which also serves the small towns in the surrounding areas. Within the collective settlements, the care and health of the people is mainly relegated to the nurses who live there. These nurses are accustomed to rugged living and to improvising equipment. They are often sent into the wilds of the Negev when new communities are in the process of being built. R.N. midwives venture into the isolated parts of the country where doctors are scarce. The proof of the success of these programs is demonstrated by comparison with earlier years. Before this program got under way Israel had one of the highest rates of death at birth in the world. Today it boasts of one of the lowest per capita, not only in the Middle East, but in the entire world.—*Davis Nursing Survey*

Rats are one of humanity's most expensive and dangerous pests. Not only do they destroy millions of dollars worth of food and merchandise annually, but they are also carriers of germs of bubonic plague. The chemical "warfarin" has been found effective in their extermination. It is produced commercially under various trade names.

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PHOSFOAM POWDER. Another Colgate quality product —for those who prefer a ready-built laundry compound. Perfectly balanced—no extra alkalis needed.

. . . Across the Desk

News Released by Hospital Supply Houses

By C.A.E.

Bauer & Black Appointments

Bauer and Black announces the appointment of John M. Huisman, as Curity representative in the Maritime Provinces.

J. M. Huisman

Mr. Huisman is a native of Holland and has worked in Australia. With this interesting background, he came to Canada where he has been engaged in the sales field in Edmonton, Alberta and latterly in Moncton, New Brunswick.

J. P. Lessard

Jean P. Lessard has been appointed as Curity hospital representative in the province of Quebec.

Mr. Lessard has been associated with Bauer and Black for nine years during which time he has been successfully selling in Quebec City and vicinity. He is married and has two daughters and now lives in the city of Montreal.

Burdick Ultrasonic Unit

A new compact portable ultrasonic unit has been announced by the Burdick Corporation of Milton, Wisconsin. More economical and convenient than standard units, the new therapeutic instrument generates sufficient power for all ordinary therapeutic purposes.

By designing a unit weighing only 25 pounds, the lightest on the market, Burdick has developed an instrument which can easily be carried from a doctor's office to a hospital or patient's home.

An output of 15 watts and effective radiating area of 6 square centimeters assure sufficient power for effective therapeutic treatment. Many automatic features add to the convenience of the instrument.

Becton, Dickinson Appoints Canadian Director

John M. Cross has been appointed director of Becton, Dickinson and Co., Canada, Ltd., and Norman S. Wright and Co., Ltd. Toronto, Ont., Canadian affiliates of Becton, Dickinson and Company, Rutherford, New Jersey.

J. M. Cross

Mr. Cross, who has been in the hospital field for 25 years, is general manager of B-D's Canadian operations. He became associated with the firm in 1951 as manager of surgical and hospital sales.

Bard-Parker Presents New Concentrate

The Bard-Parker Co. presents Halimide, a new concentrate of low surface tension and excellent penetrating qualities scientifically perfected for inexpensive instrument disinfection.

Halimide is rapidly bactericidal, non-selective and tuberculocidal when diluted with alcohol. It is non-corrosive — no anti-rust tablets to add; stable —need not be changed frequently; inexpensive — 1 oz. makes a gal. of solution.

(Concluded on page 138)

MATHEWS BUILDS THE BEST IN CONVEYERS FOR CANADA'S HOSPITALS

Mathews Conveyers can be seen in service in Hospitals all over Canada.

● Vertical Selective Tray Conveyers. ● Ascending & Descending Conveyers for fast, efficient food handling to all floors. ● Hoists for prescriptions, charts, and miscellaneous documents. ● All units quietly automatic and selective in operation.

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SANITATION FOR THE NATION

G.H. Wood's self-closing all steel, waste receptacles

- Keeps washrooms tidy
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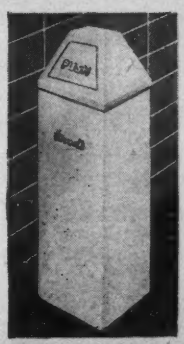
A style and size for every Waste Receptacle purpose!



G. H. WOOD & COMPANY'S HEAD OFFICE, LABORATORY AND FACTORY

G. H. WOOD & COMPANY LIMITED

KEEP DISHWASHING COMPOUNDS AT FULL STRENGTH *automatically* with Syndet CONTROLS

You don't have to depend on an operator's memory — any longer — to keep dishwashing compounds at the proper strength. Syndet Controls turn on automatically as soon as water is added to the tank of your dishwashing machine. They add just the right amount of compound to bring the solution to the correct concentration. And, they continue to do so every time fresh water is added — so that dishes are always washed sanitary clean.

a choice of controls to suit your needs!

THE ULTROMETER
For Single Tank Machines

Coloured dial marked LO, OK and HI constantly shows how much compound is in the tank. Turns itself on as soon as water is added.

THE ULTROMETER—
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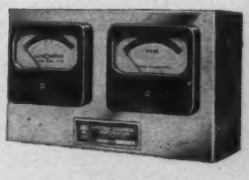
Gives a reading on both wash and rinse tanks, so that you know when your rinse water requires changing.



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This stainless steel automatic dispenser not only replaces the compound lost down the drain each time the rinse is operated but adds the initial compound as well.

COMPOUND FORMULAS for SPECIAL WATER CONDITIONS

For the most efficient economical cleaning you should use a compound formula best suited for your local water condition. McKemco Phos-Brite is prepared to answer your needs. We take a test of your local water—then set up your ultrometer to give you the best results.

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Across the Desk

(Concluded from page 136)

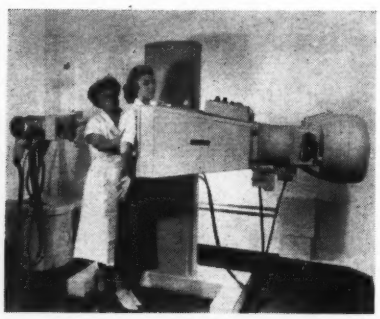
D. Meek

Stevens Appointment

The Stevens Companies announce the appointment of Mr. D. Meek to their sales staff. Mr. Meek will service the Central Alberta area including a portion of Edmonton. His headquarters will be in Edmonton, Alberta.

Mirrors Cut X-Ray Exposure

A 70 to 75 per cent reduction in x-ray exposure to the patient is achieved by a new type of small-film chest x-ray machine announced by the X-Ray Department of General Electric Co. in Milwaukee. The camera portion of the unit is produced by the Fairchild Camera and Instrument Corp., Jamaica, N.Y.



Heart of the new unit is a special mirror, which applies the same principle that is employed by astronomers to photograph light from the distant stars. The reduction in x-ray exposure is made possible by the mirror's optical speed, which is between 4 and 5 times greater than that of refractive lens-type photo-roentgen cameras hitherto used in chest x-ray surveys.

The large-diameter mirror system, similar to those used in giant telescopes, is also reported to produce sharper and clearer images than have hitherto been possible. This system permits an extremely wide working aperture of f/0.7 (GRA f/0.65). Resolution of the x-ray image is 4 times that of refractive-type lens camera previously employed in small-film chest x-ray work, resulting in images that are considered of high diagnostic quality.

Because of the smaller current and shorter exposure times required to produce a diagnostic image on the film, the life of the x-ray tube may be conserved through use of the new camera.

Parke-Davis Dedicates New $2,000,000 Canadian Laboratories

Parke, Davis and Company, Ltd., reached a new high point in its 70-year Canadian history on September 13th when over 100 leaders of government, industry, pharmacy and medicine joined in dedicating the firm's new $2,000,000 pharmaceutical laboratories at Brockville, Ont.

Parke-Davis President Harry J. Loynd, in response to Brockville Mayor J. W. C. Langmuir's dedication address, said the opening of the laboratories is "the latest forward step" in meeting the firm's two-fold obligation to Canadian health needs. This obligation, he said, "is not only to make good products, but to have them in adequate supply, quickly, and ready for use, whenever and wherever they may be needed".

He pointed out that construction of the multi-million dollar laboratories was the fourth step taken within the past 18 months to better meet that obligation. In April, 1955, the firm opened new Canadian sales headquarters in Toronto; then established new branches in Edmonton and Vancouver last January. Parke-Davis also has branches in Montreal and Winnipeg.

Mr. Loynd, who headed a group of top Parke-Davis executives from Canada and the United States at the ceremonies, said Brockville was selected from among 15 other locations as the site for the new laboratories. "But", he pointed out, "in this fine and growing country, it would be difficult to make an unwise decision in selecting such a site".

George C. Shannon, superintendent of the new laboratories and a native of nearby Prescott, Ont., escorted the guests through the new facilities following the ceremony.

The laboratories, among the most modern in Canada, occupy 20 acres and have 150,000 square feet of floor space. The firm constructed Canada's first pharmaceutical laboratories at Walkerville, Ont., in 1886.

Artificial Bifurcated Aorta

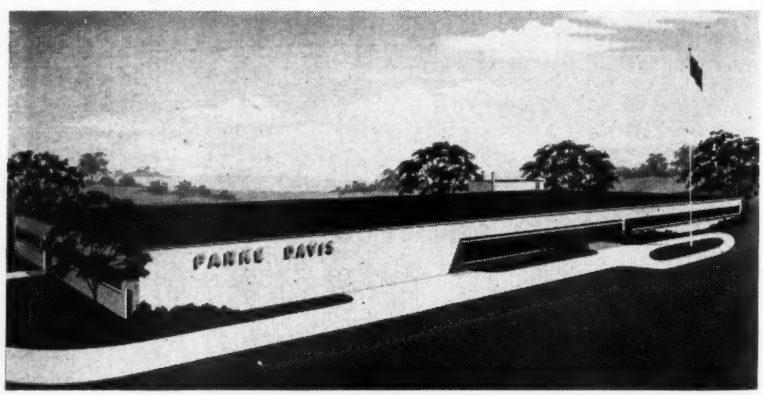
There is now available to surgeons an artificial bifurcated aorta. This new arterial graft is a "Y" type Edwards-Tapp A-G TM Tube produced by the United States Catheter and Instrument Corporation under license from The Chemstrand Corporation.

Manufacture of this "Y" tube required the development of an entirely new braiding machine. The tubes are made of braided nylon and chemically treated to weld together all of the strands. The first tubes available have a ⅝ in. lumen in the large tube and the branches have a lumen of ⅜ in. Other sizes will be made later if there is sufficient need for them. The large part of the tube is 5 in. long and the limbs are each 9½ in. long.

Directions prepared by Dr. W. Sterling Edwards to explain to surgeons the technique for inserting this graft are enclosed in each package.

Benjamin Minge Duggar

Dr. Benjamin Minge Duggar, discoverer of the antibiotic Aureomycin chlortetracycline, died Sept. 10th, at the age of 84, at Grace Memorial Hospital, New Haven, Conn. In 1945, Dr. Duggar made his discovery of Aureomycin at the Lederle Laboratories of American Cyanamid Company, Pearl River, N.Y. It was the result of two years of research in which he tested thousands of strains of antinomycetes, isolated from soil samples collected from many parts of the world.



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